HYGIENE OF MATERNITY AND INFANCY

HEARINGS

BEFORE

THE COMMITTEE ON LABOR

HOUSE OF REPRESENTATIVES

SIXTY-FIFTH CONGRESS

THIRD SESSION

ON

1919

H. R. 12634

A BILL TO ENCOURAGE INSTRUCTION IN THE HYGIENE OF MATERNITY AND INFANCY, AND TO EXTEND PROPER CARE FOR MATERNITY AND INFANCY; TO PROVIDE FOR COOPERATION WITH THE STATES IN THE PROMOTION OF SUCH INSTRUCTION AND CARE IN RURAL DISTRICTS; TO APPROPRIATE MONEY AND REGULATE ITS EXPENDITURE, AND FOR OTHER PURPOSES

WEDNESDAY, JANUARY 15, 1919
TUESDAY, JANUARY 28, 1919

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SIXTY-FIFTH CONGRESS.

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HYGIENE OF MATERNITY AND INFANCY.

COMMITTEE ON LABOR,
HOUSE OF REPRESENTATIVES,
Washington, D. C., January 15, 1919.

The committee met at 10.30 o'clock a. m., Hon. James P. Maher (chairman), presiding.

The CHAIRMAN. The committee will hear Miss Rankin in connection with H. R. 12634, which is as follows:

[H. R. 12634, Sixty-fifth Congress, Second Session.]

A BILL To encourage instruction in the hygiene of maternity and infancy, and to extend proper care for maternity and infancy; to provide for cooperation with the States in the promotion of such instruction and care in rural districts; to appropriate money and regulate its expenditure, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled That there is hereby annually appropriated, out of any money in the Treasury not otherwise appropriated, the sums provided in section two of this act, to be paid to the several States for the purpose of cooperating with the States in promoting the care of maternity and infancy in rural districts; to provide instruction in the hygiene of maternity and infancy, and the sum provided in section five for the use of the Chief of the Children's Bureau Department of Labor, for the administration of this act and for the purpose of making such studies, investigations, and reports as will further the efficient administration of this act.

SEC. 2. That for the purpose of paying the expenses of said cooperative work in providing the services and facilities specified in this act, and the necessary printing and distribution of information in connection with the same, there is permanently appropriated, out of any money in the Treasury not otherwise appropriated, the sum of $480,000 for each year $10 000 of which shall be paid annually to each State, in the manner hereinafter provided: *Provided*, That there is also appropriated for the use of the States, subject to the provisions of this act, for the fiscal year ending June thirtieth, nineteen hundred and nineteen, an additional sum of $1 000,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty, the sum of $1,200,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-one, the sum of $1,400,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-two, the sum of $1,600 000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-three, the sum of $1,800,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-four, the sum of $2 000 000; and annually thereafter the sum of $2,000,000: *Provided further*, That no payment out of the additional appropriations herein provided shall be made in any year to any State until an equal sum has been appropriated for that year by the legislature of such State for the maintenance of the services and facilities provided for in this act.

So much of the appropriation apportioned to any State for any fiscal year as remains unexpended at the close thereof shall be avialable for expenditures in that State until the close of the succeeding fiscal year. Any amount apportioned under the provisions of this act unexpended at the end of the period during which it is available for expenditure under the terms of this section shall be reapportioned, within sixty days thereafter, to all the States in the same manner and on the same basis, and certified to the Secretary of the Treasury and to the State boards of maternity and infant hygiene in the same way as if it were being apportioned under this act for the first time.

SEC. 3. That in order to secure the benefits of the appropriations provided for in section two of this act, any State shall, through the legislative authority thereof, accept the provisions of this act and designate or authorize the creation of a State board of maternity aid and infant hygiene, which shall have all necessary power to cooperate as herein provided, with the Chief of the Children's Bureau, Department of Labor, in the administration of the provisions of this act; the members of the State board shall

be appointed by the governor and shall consist of the following persons: The governor, ex officio, who shall be chairman of the board; a representative of the State board of health, who shall be a physician; a representative of the nursing profession, who shall be a graduate nurse, and in States where registration obtains shall be duly registered; a representative of the teaching profession, who shall be selected from the State university or the State college of agriculture. The first meeting of said board shall be called by the governor, at such time and place as he may direct; the board shall elect a vice chairman and a secretary, and shall notify the chief of the Children's Bureau, Department of Labor, of the assent of the State to the provisions of this act and shall state the name and address of the officer authorized to conduct the correspondence of the board.

In any State the legislature of which does not meet in nineteen hundred and nineteen the governor of that State, so far as he is authorized to do so, shall accept the provisions of this act and designate or create a State board of not less than three members to act in cooperation with the Chief of the Children's Bureau, Department of Labor. The Chief of the Children's Bureau shall recognize such local board for the purposes of this act until the legislature of such State meets in due course and has been in session sixty days.

SEC. 4. That the Chief of the Children's Bureau, under the direction and control of the Secretary of Labor, shall have charge of all matters concerning the administration of this Act, and shall have power to cooperate with State boards in carrying out the provisions of this act. It shall be the duty of the Chief of the Children's Bureau, under the direction or with the approval of the Secretary of Labor, to make or cause to have made, such studies, investigations, and reports as will further the efficient administration of this act.

SEC. 5. That so much, not to exceed five per centum of the appropriation for any fiscal year made by or under this act, as the Chief of the Children's Bureau, with the approval of the Secretary of Labor, may estimate to be necessary for administering the provisions of this act, shall be deducted for that purpose, available until expended. Within sixty days after the close of each fiscal year the Chief of the Children's Bureau, under the direction or with the approval of the Secretary of Labor, shall determine what part, if any, of the sums theretofore deducted for administering the provisions of this act will not be needed for that purpose and apportion such part, if any, for the fiscal year then current in the same manner and on the same basis, and certify it to the Secretary of the Treasury and to the State boards of maternity aid and infant hygiene, in the same way as other amounts authorized by this act to be apportioned among all the States for such current fiscal year. The Secretary of Labor, after making the deduction authorized by this section, shall apportion the remainder of the appropriation for each fiscal year among the several States in the proportion which the rural population of each State bears to the total rural population of all the States as determined by the next preceding Federal census.

SEC. 6. That out of the appropriations made by or under this act, the Secretary of Labor, upon the recommendation of the Chief of the Children's Bureau, is authorized to employ such assistants, clerks, and other persons in the city of Washington and elsewhere, to rent buildings outside of the city of Washington, to purchase such supplies, material, equipment, office fixtures, and apparatus, and to incur such travel and other expense as he may deem necessary for carrying out the purposes of this act.

SEC. 7. That within sixty days after the approval of this act the Secretary of Labor shall certify to the Secretary of the Treasury and to each State board of maternity aid and infant hygiene the sum which he has estimated to be deducted for administering the provisions of this act, and the sum which he has apportioned to each State for the fiscal year ending June thirtieth, nineteen hundred and nineteen, and on or before January twentieth next preceding the commencement of each succeeding fiscal year shall make like certificates for such fiscal year.

SEC. 8. That any State desiring to avail itself of the benefits of this act shall, by its board of maternity aid and infant hygiene, submit to the Secretary of Labor detailed plans for carrying out the provisions of this act. These plans shall include the provisions made in the State for the administration of the act; the provision of instruction in the hygiene of maternity and infancy through public-health nursing, consultation centers, and other suitable methods; and the provision of medical and nursing care for mothers and infants at home or at a hospital when necessary, especially in remote areas. If the Chief of the Children's Bureau finds the same to be in conformity with the provisions and purposes of this act, the same shall be approved under the direction of the Secretary of Labor.

SEC. 9. That in order to provide popular, nontechnical instruction to the residents of the various States, particularly to those to whom such facilities are not accessible, on

the subject of the hygiene of infancy, hygiene of maternity, and related subjects, the State board of maternity aid and infant hygiene is authorized to arrange with the State university, land-grant college, or other educational institution for the provision of extension courses by qualified lectures: *Provided*, That not more than twenty-five per centum of the sums granted by the United States to a State under this act may be used for this purpose.

SEC. 10. That in order to receive the benefits of the appropriations provided under this act the State shall, through the legislative authority thereof, appoint as custodian for said moneys its State treasurer, who shall receive and provide for the proper custody of such money and its disbursement on rquisition of the State board of maternity aid and infant hygiene.

SEC. 11. That the facilities provided by the State board of maternity aid and infant hygiene under the provisions of this act shall be available for all residents of the State, but the State board may require persons receiving specified services to pay a fee for the same under regulations approved by the Secretary of Labor: *Provided*, That moneys collected under this section shall be turned over to the State treasurer and deposited in the fund used for the purposes and expenses of carrying this act into effect.

SEC. 12. That the Chief of the Children's Bureau, Department of Labor, shall every three months ascertain the amounts expended by the several State boards of maternity aid and infant hygiene in the preceding quarter year. On or before the first day of January and quarterly thereafter the Secretary of Labor shall certify to the Secretary of the Treasury the amount to which each State is entitled under the provisions of this act. Upon such certification the Secretary of the Treasury shall pay to the State treasurer as custodian the amounts so certified.

SEC. 13. That the State board of maternity aid and infant hygiene shall make such reports concerning its operations and its expenditures of funds as shall be prescribed by the Chief of the Children's Bureau, with the approval or under the direction of the Secretary of Labor. If the Secretary of Labor determines that any moneys provided under this act are not being expended for the purposes and under the conditions of this act, he may decline to approve any further allotments to such State.

SEC. 14. That if any portion of the moneys received by the treasurer of any State as custodian under this act shall, by any action or contingency, be diminished or lost, it shall be replaced by such State, and until so replaced no subsequent allotment under this act shall be paid to such State. No portion of any moneys appropriated under this act for the benefits of the States shall be applied, directly or indirectly, to the purchase, erection, preservation, or repair of any building or buildings or equipment, or for the purchase or rental of any building or lands.

SEC. 15. That the receipt by any person of aid under this act shall not be construed as the receipt of charitable relief, and shall not in any way affect unfavorably the legal status of such person.

SEC. 16. That the Secretary of Labor shall include in his annual report to Congress a full account of the administration of this act and of the expenditures of the moneys herein provided.

STATEMENT OF MISS JEANNETTE RANKIN, REPRESENTATIVE IN CONGRESS FROM THE STATE OF MONTANA.

Miss RANKIN. I have prepared a little synopsis of the bill. Section 1 of the bill provides for an appropriation of money to be paid to the States for the purposes of cooperating with the States in promoting the care of maternity and infancy in rural districts; and to provide instruction in the hygiene of maternity and infancy.

Section 2 calls for the sum of $480,000 to be permanently appropriated each year, $10,000 of which shall be paid annually to each State; also an added sum of $1,000,000 for the first year, this sum to be increased $200,000 each year until it reaches the sum of $2,000,000. These supplementary allowances must be equaled by State appropriation. The allotments to States are to be made on the basis of relation of the rural population of State to total rural population of United States by last preceding Federal census. Any unexpended State apportionment at the close of the fiscal year shall be available for the State until the close of succeeding fiscal year. If still unexpended, it

shall be reapportioned within 60 days to all the States as if it were being apportioned for the first time.

Section 3 provides that to secure the benefits of the act the State legislature must accept its provisions and authorize the creation of a State board of maternity aid and infant hygiene, with power to cooperate with the Chief of the Children's Bureau, Department of Labor, in its administration. The State board is to be appointed by the governor, of which he is to be ex-officio chairman, composed of a physician from the State board of health, a registered nurse, a teacher from the university or agricultural college. I want to offer an amendment later providing for three women on that board. The board is to elect its vice chairman and secretary, and notify the Chief of the Children's Bureau of the assent of the State. Where the legislature does not meet within a year of the passage of the act, the governor shall accept the provisions and create a board to cooperate with the Chief of the Children's Bureau. The Chief of the Children's Bureau shall recognize such board until the first legislature has been in session 60 days.

Section 4 provides that the Chief of the Children's Bureau shall have the administration of the act and shall cooperate with the State boards; shall also make studies, investigations, and reports that will further its effective administration.

Section 5: The cost of Federal administration is not to exceed 5 per cent of the total amount appropriated during a given year. The allotments to the State shall be made on the basis of the relation that the rural population of each State bears to total population of the United States by the last preceding Federal census.

Section 6: The Secretary of Labor is authorized to employ assistants, and so forth, in the city of Washington and elsewhere, to rent buldings, purchase supplies, and so forth, and to incur other necessary expenses.

Section 7 provides that within 60 days of the approval of the act the Secretary of Labor shall certify to the Secretary of the Treasury and to each State board of maternity aid and infant hygiene the sum he estimated to be apportioned to each State.

Section 8: States desiring to avail themselves of the act shall submit to the Secretary of Labor detailed plans for work. These plans shall include the provisions for administration, for instruction in the hygiene of maternity and infancy, for medical and nursing care for mothers and infants, especially in remote areas.

In section 9, that extension courses may be arranged for in educational institutions, but not more than 25 per cent of sum granted to State to be so expended.

Section 10: That the State, through legislative authority, shall appoint the State treasurer custodian of the funds.

Section 11: That a fee may be required for the facilities provided, but it must be turned into the fund.

Section 12: That the Chief of the Children's Bureau shall report money spent in each State every three months.

Section 13: That the State board shall report, and if the Secretary of Labor determines money is not properly expended he may decline to approve further allotments.

Section 14: That the States shall be held responsible for the money given them, and no money is to be used for buildings, equipment, or rent.

Section 15: That the act is not a charity.

Section 16: That the Secretary of Labor shall include in his annual report to Congress a full account of the administration of the act.

Miss Fleming, the assistant chief of the bureau, is here and has prepared a brief which she desires to read to the committee.

STATEMENT OF MISS CAROLINE FLEMING, CHILDREN'S BUREAU, UNITED STATES DEPARTMENT OF LABOR.

Miss FLEMING (reading):

BRIEF FOR MATERNITY AND INFANCY BILL.

INTRODUCTION.

The maternity and infancy bill would place with the Secretary of Labor and the Chief of the Children's Bureau the responsibility for its administration, so far as the Federal Government is concerned. The Department of Labor is a department to promote human welfare, one of whose duties it is to ascertain adequate standards of life. The Children's Bureau, in the bill establishing it in 1912, was assigned by Congress the whole field of child welfare, and no other branch of the Government is concerned with child welfare as a whole. During the six years of its existence it has been making a careful study of infant and maternal mortality, of the most successful methods of carrying on infant welfare work, of obtaining for mothers proper prenatal supervision and instruction, and the possibility of adequate obstetrical care. As a result of these studies it has published many bulletins and leaflets, which have increased the general interest in these vital matters and widened the realization of the importance of maternal and child welfare to the Nation.

Many communities throughout the United States have been led by these studies to consult the Children's Bureau as to the best way of starting and developing infant and prenatal work.

Special surveys made by the Children's Bureau in rural communities have furnished knowledge of the actual conditions existing in many types of rural districts in different parts of the country, and through these investigations the bureau has awakened the public to the urgent need of rural work for mothers and children. Information obtained from these careful studies of rural conditions has prepared the Childrens' Bureau for the task of making plans for the administration of the proposed measure. A summary of the important points which prove the need for this Federal measure for protection of maternity and infancy follows:

1. At least 16,000 women die every year in the United States from childbirth, and uncounted thousands suffer impairment of health from causes related to maternity.

Approximately one-quarter of a million babies die every year within 12 months of birth. At least one-half of these deaths occur within the first six weeks after birth.

2. From the last available figures maternal death rates are apparently higher in the United States than in 13 other principal countries and show no decrease from year to year.

Of the maternal deaths in the United States about 7,000 are assigned to childbed fever, a disease almost entirely preventable, and about 9,000 are assigned to other conditions which may frequently be prevented or cured.

3. Infant mortality rates are higher in the United States than in 10 other principal countries. Within the first year after birth we lose 1 in 10 of all babies born; New Zealand loses 1 in 20.

While almost one-fourth of the infant deaths in the United States are ascribed to gastric and intestinal diseases, which result from improper care and feeding of the baby, over two-fifths are due to prenatal and natal conditions.

4. Considerably more than one-half of the babies in the United States are born in rural areas, and these show the same high infant mortality that is found in cities from causes related to the care and condition of the mother.

The infant mortality rate from other causes is slightly less in rural areas than in cities, but in the rural areas of the United States it is far greater than the corresponding rate for New Zealand as a whole.

5. The Children's Bureau studies in rural areas in different States have revealed—

(*a*) High maternal mortality rates, above the average for the United States as a whole.

(*b*) That a majority of mothers have received no advice or trained care during pregnancy, and may have had no trained attendance of any kind at confinement.

(c) Inaccessibility and often entire lack of hospitals, doctors, and nurses.

(d) Practically no organized effort to meet the need for instruction in prenatal and infant hygiene and for trained care during pregnancy and confinement.

(e) A many times larger cost for providing adequate care at confinement in scattered and isolated rural districts compared with cities. The very districts where advice and supervision during pregnancy and better help at confinement are most needed are the ones least able to obtain it without financial aid.

6. The neglect of mothers and babies in rural areas, and the resulting losses of life and vigor are matters of grave concern. The Nation can not afford such waste of human resources.

New Zealand has reduced her infant mortality rate to the lowest point achieved by any country by a system of instructive nursing and Government maternity hospitals which make instruction and care accessible to all mothers. The work is largely subsidized by Government funds.

Canada, with vast, sparsely settled districts, similar to those in certain of our States, has realized that one of its greatest needs is provision for nursing and hospital care for maternity cases and for the sick, and of preventive nursing work in these rural districts. The western Provinces have already developed plans for rural nursing and hospital work, subsidized by the provincial governments.

England and Whales achieved in 1916, in spite of war-time conditions, the lowest infant mortality rate in their history. Health visitors and consultation centers have been encouraged since 1914 and greatly extended through grants in aid from the national treasury to local authorities and recognized agencies. The maternity and child welfare act was passed in August, 1918, during the crisis of the war.

Before the war France led the way in all infant welfare work, and recognized the duty of the state to protect maternity. As early as 1910, a law was passed providing that women should be cared for in institutions at public expense for one month before and one month after confinement. Measures for safeguarding pregnant and nursing mothers and their babies were considerably aided by State subsidies to private agencies. Such work has not been relaxed since the war.

During the first month of the war, the military government of Paris organized a central office of maternity aid "to assure to every woman who is pregnant, or who has a baby less than 3 years old, the social, legal, and medical protection to which she has a right in a civilized society—to be sure that no woman is ignored and that no child is forgotten."

7. Standard methods of infant welfare work and maternity care have been developed in recent years in this country and are being extended in many cities.

8. Abundant precedent for Federal aid to State work in rural areas is found in existing legislation for promoting scientific farming, teaching home economics, protecting the health of domestic animals, and building good roads.

9. The present bill would stimulate the development in rural ares of visiting nursing, consultation centers for mothers and babies, hospital care for mothers in remote districts, and courses of instruction in maternal and infant hygiene.

10. Like the Smith-Lever Act, this bill is primarily for the purpose of educational extension. The former brings the most medern knowledge of scientific farming and home economics to the farmer and his wife in their home, recognizing that actual demonstration is the best way to teach. In the same way, this measure would bring to the woman on the farm modern knowledge about the care of children and her own care during pregnancy and confinement.

11. Like the Smith-Lever Act, each State adopting its provisions is granted a sum of $10,000, with which work can be immediately organized in selected counties. The additional appropriation, rising from a total of $1,000,000 the first year, to a total of $2,000,000 after five years, is apportioned to the States on the basis of their rural population; a State receives its share of the additional sum only after an equal amount has been appropriated by the State legislature.

12. A high standard of State work would be required. All State plans must be approved by the Secretary of Labor and the Chief of the Children's Bureau, and the amount which may be deducted for Federal administration (a sum not greater than 5 per cent of the total appropriation) is intended to permit a first-hand knowledge by the Children's Bureau of the work that is carried on in the States.

13. Administration in each State is placed with a board consisting of the governor of the State and three other persons representing the three professions whose cooperation is indispensable, a physician, a nurse, and a teacher; and in order that the work may be efficiently developed in cooperation with existing agencies, the physician must represent the State board of health, and the teacher must represent the State university, or the State college of agriculture.

SUPPLEMENT TO BRIEF.[1]

1. Sixteen thousand deaths annually from causes related to childbirth is a conservative estimate for the United States, based on the 1916 figures for the death registration area.

More women between the ages of 15 and 44 die from causes related to childbirth than from any other one cause except tuberculosis.

The number of infant deaths in the United States must also be estimated from the number reported in the death registration area. In 1916, 164,660 infants wunder one year died in the death registration area, which included 70.2 per cent of the estimated population of continental United States. If the death registration area included the same percentage (70.2) of all the infant deaths in the United States, the total number would be at least 235,229. Over 117,000 of this number may be estimated to have died during the first six weeks after birth.

2. The following tables show, first, maternal death rates per 100,000 population in the death registration area of the United States 1890, and year by year from 1900 to 1916, and second, average maternal death rates per 100,000 population in the death registration area of the United States and in 15 foreign countries for a series of years from 1900 to 1910.

TABLE I.—*Population, deaths, and death rates per 100,000 population in the death registration area, from diseases caused by pregnancy and confinement: 1890, and 1900 to 1916.*

Year.[2]	Population of death registration area.		Deaths from diseases caused by pregnancy and confinement.					
			Number			Rate per 100,000 population.		
	Total	Per cent of population of United States.	Total.	Puerperal septicemia.	All other.	Total.	Puerperal septicemia.	All other.
1890[3]	19,659,440	31.4	3,011	[4] 1,383	1,629	15.3	[4] 7.0	8.3
1900[3]	28,807,269	37.9	3,772	[4] 1,619	2,153	13.1	[4] 5.6	7.5
1900	30,765,618	40.5	4,106	1,769	2,337	13.3	5.7	7.6
1901	31,370,952	40.3	4,294	1,882	2,412	13.7	6.0	7.7
1902	32,029,815	40.4	4,164	1,813	2,351	13.0	5.7	7.3
1903	32,701,083	40.4	4,569	1,992	2,577	14.0	6.1	7.9
1904	33,345,163	40.4	5,109	2,291	2,818	15.3	6.9	8.5
1905	34,052,201	40.4	5,077	2,309	2,768	14.9	6.8	8.1
1906	41,983,419	48.9	6,341	2,622	3,719	15.1	6.2	8.9
1907	43,016,990	49.2	6,719	2,908	3,811	15.6	6.8	8.9
1908	46,789,913	52.5	7,344	3,271	4,073	15.7	7.0	8.7
1909	50,870,518	56.1	7,791	3,427	4,364	15.3	6.7	8.6
1910	53,843,896	58.3	8,455	3,892	4,563	15.7	7.2	8.5
1911	59,275,977	63.1	9,456	4,376	5,080	16.0	7.4	8.6
1912	60,427,247	63.2	9,035	3,905	5,130	15.0	6.5	8.5
1913	63,298,718	65.1	10,010	4,542	5,468	15.8	7.2	8.6
1914	65,989,295	66.8	10,518	4,664	5,854	15.9	7.1	8.9
1915	67,336,992	67.1	10,237	4,214	6,023	15.2	6.3	8.9
1916	71,621,632	70.2	11,642	4,786	6,856	16.3	6.7	9.6
Annual average:								
1901 to 1905	32,699,843	.....	4,643	2,057	2,586	14.2	6.3	7.9
1906 to 1910	47,300,947	.....	7,330	3,224	4,106	15.5	6.8	8.7
1911 to 1915	63,265,646	.....	9,851	4,340	5,511	15.6	6.9	8.7

[1] Paragraph numbers refer to corresponding numbers in brief.
[2] Calendar year unless otherwise specified.
[3] Census year ending May 31.
[4] Figures for puerperal septicemia for the census years 1890 and 1900 not comparable with those for later years.

TABLE II.—*Average death rates per 100,000 population in certain countries from diseases caused by pregnancy and confinement, 1900 to 1910.*

Country.	Death rate per 100,000 population from diseases caused by pregnancy and confinement.			Country.	Death rate per 100,000 population from diseases caused by pregnancy and confinement.		
	Total.	Puerperal septicemia.	All other.		Total.	Puerperal septicemia.	All other.
Sweden [1]	6.0	2.4	3.5	Japan [1]	13.3	4.5	8.8
Norway	8.1	4.1	3.9	Australia [5]	14.1	4.7	9.4
Italy	8.9	3.3	5.7	Belgium [3]	14.8	5.8	9.0
France [2]	10.3	4.8	5.5	Scotland [1]	14.8	5.5	9.4
Prussia [3]	10.4	4.7	5.8	United States [6]	14.9	6.5	8.3
England and Wales	11.1	4.7	6.5	Switzerland	15.2	6.4	8.8
New Zealand	12.4	3.1	9.3	Spain [1]	19.6	12.3	7.3
Ireland [4]	12.9	4.5	8.4	Austria	(7)	6.6	(7)
Hungary	13.3	3.6	9.8				

[1] Rates based on figures for 1901 to 1910
[2] Rates based on figures for 1906 to 1910.
[3] Rates based on figures for 1903 to 1910.
[4] Rates based on figures for 1902 to 1910.
[5] Rates based on figures for 1907 to 1910.
[6] Rates based on figures for death-registration area which increased from year to year: in 1900 it comprised 40.5 per cent of the total population of the United States and in 1910, 58.3 per cent.
[7] Figures not available.

It will be noted that the maternal death rate in the death registration area of the United States has not decreased since 1900. During the same period the death rates from other preventable diseases have been markedly reduced. The death rate from typhoid fever has been cut in half; and that from diphtheria and croup has dropped to less than one-third; those from tuberculosis and pneumonia have both shown a decided fall.

Only 2 of the 15 foreign countries show rates from conditions caused by childbirth higher than the rate in the death registration area of the United States. The rates of three countries, Sweden, Norway, and Italy, which are notably low, show that better rates from maternal mortality than those prevailing in the United States are attainable.

A more accurate measure of maternal mortality is found in comparing the number of maternal deaths with the number of life births. Such data are available only for the birth registration area of the United States for the three years, 1910, 1915, and 1916. On this basis, also, the rate in the United States is higher than the rate in foreign countries.

TABLE III.—*Death rate per 1,000 live births from all causes related to pregnancy and confinement in the birth registration area* [1] *of the United States for specified years.*

Year.	Total.	Puerperal septicemia.	All other.
1910	6.5	2.9	3.6
1915	6.1	2.4	3.7
1916	6.2	2.5	3.7

[1] The birth registration area included 24.1 per cent of the population of continental United States in 1910, 31.0 per cent in 1915, and 32.4 per cent in 1916.

Puerperal septicemia (childbed fever), to which nearly 7,000 deaths are assigned annually in the United States, is an infection which can usually be prevented by the same measures of cleanliness and asepsis which are used universally in modern surgery. Although puerperal infection may usually be attributed to the hands of the attendant, women may occasionally infect themselves through improper hygiene during pregnancy or confinement. Therefore, prenatal instruction and supervision is an essential part of the work for the prevention of this infection.

The second group of deaths related to childbirth, of which there are about 9,000 annually in the United States, includes deaths from many different conditions. A large number of these complications can be prevented through proper hygiene and supervision during pregnancy and through skilled care at labor. Certain other

complications which as yet can not be prevented can be detected before se is done, and treatment can be given which will save the mother's life.

For a fuller discussion of comparative death rates and of the preven maternal deaths, see the bulletin on Maternal Mortality, prepared by Grac M. D., and published by the Children's Bureau, United States Department of in 1917, submitted herewith.

3. In the birth registration area of the United States, the infant mortality rate was 99.9 per 1,000 live births in 1915, and 101.0 per 1,000 live births in 1916. The following list shows the latest available infant mortality rates in the birth registration area of the United States and in 10 foreign countries.

TABLE IV.—*Infant mortality rates in different countries for specified year. (Deaths under 1 year per 1,000 live births.)*

Country.	Infant mortality rate.[1]	Country.	Infant mortality rate.[1]
New Zealand (1916)[2]	51	Switzerland (1914)	91
Australian Commonwealth (1915)	68	Ireland (1916)	83
Norway (1914)	68	Denmark (1915)	95
Sweden (1913)	70	England and Wales (1916)[3]	91
France (1912)	78	United States (birth registration area, 1916)	101
Netherlands (1915)	87		

[1] All rates with the exception of those for New Zealand and England and Wales were obtained from Birth Statistics, 1916, Bureau of the Census, p. 19.
[2] The New Zealand Official Year Book, 1917, p. 104.
[3] Seventy-ninth Annual Report of the Registrar General of Births, Deaths, and Marriages in England and Wales, 1916, p. LXXXV.

The 164,660 deaths under 1 year of age, in 1916, in the death registration area, which included in 1916, 70.2 per cent of the population, may be distributed among the main groups of causes as follows:

TABLE V.—*Infant deaths during 1916, in the death registration area of the United States,[1] by age and cause of death.*

Cause of death.	Infant deaths during 1916 in the death registration area.		
	Total.	Under 1 month.	1 month, but less than 1 year.
All causes	164,660	75,583	89,077
Prenatal and natal causes (conditions related to the mother)[1]	68,509	57,730	10,779
Premature birth	33,123	31,661	1,462
Congenital debility	16,281	10,626	5,655
Malformations	10,638	8,334	2,304
Injuries at birth	6,274	6,199	75
Syphilis	2,193	910	1,283
Other causes	96,151	17,853	78,298
Gastric and intestinal diseases	39,327	4,753	34,574
Respiratory diseases	23,716	4,244	19,472
Other communicable diseases	13,162	1,457	11,705
All other causes	19,946	7,399	12,547

[1] During the first year of life, deaths from prenatal and natal conditions form 41.6 per cent of infant deaths from all causes.

Compiled from Mortality Statistics, U. S. Bureau of the Census, 1916.

The infant deaths from prematurity, congenital debility, and injuries at birth, which are often assembled under the heading "diseases of early infancy," and the infant deaths from syphilis are due to conditions which can be directly influenced by the care the mother receives during pregnancy and confinement. These deaths, with those from malformation, the cause of which is as yet undetermined, form a group dependent upon prenatal and natal causes, which total 41.6 per cent of all the

deaths during the first year of life. Moreover, it is generally accepted that the paramount factors causing the deaths during the first month of life are, also, the prenatal condition of the mother and the care she received during pregnancy and confinement. Therefore, the 17,853 deaths occurring within the first month after birth in 1916, but assigned to causes other than prenatal or natal, might also have been largely prevented by making accessible to every mother instruction and supervision in proper prenatal care and skilled assistance during confinement.

The importance of maternal care in the prevention of infant deaths does not stop, however, with these early deaths and deaths from special causes. During the greater part of the first year of life breast feeding is the chief source of protection from all diseases. Scientific observations show that mothers who receive proper care during pregnancy, confinement, and the lying-in period are most apt to nurse their babies.

Gastric and intestinal diseases are obviously related to the care and feeding of the baby; it is also true that in the prevention of respiratory and other communicable diseases the mother's knowledge of how to care for her baby in health is a very important factor. To obtain this knowledge, the mother should be able to consult a physician and to receive from him instruction as to the needs of her child, and should have also in her own home, supervision and instruction by a nurse in the proper care of her infant.

4. In the census of 1910, 60 per cent of all children under 1 year of age were found in rural areas (country districts and places where the population is less than 2,500); less than 1 per cent of all the children under 1 year of age, either in rural or urban areas, were born outside of the United States.

The only infant mortality rates available for the urban and rural districts of the birth registration area are based on a definition of rural as "exclusive of municipalities having a population of 10,000 or more in 1910." The following urban and rural infant mortality rates are compiled from an unpublished analysis of the 1915 statistics furnished the Children's Bureau by the Bureau of Census.

TABLE VI.—*Infant mortality rates for urban and rural areas of the birth registration area, 1915, by age and cause of death (deaths under 1 year per 1,000 live births).*

Cause of death, urban and rural areas.	Age at death.		
	Total deaths under 1 year.	Total deaths under 1 month.	Total deaths, 1 month, but less than 1 year.
TOTAL BIRTH REGISTRATION AREA 1915.			
All causes	99.9	44.4	55.6
Gastric and intestinal diseases	24.7	2.9	21.7
Respiratory diseases	16.7	2.9	13.8
Malformations	6.4	5.0	1.4
Diseases of early infancy	34.5	28.7	5.8
Syphilis	1.2	.5	.7
Other communicable diseases	6.5	.6	5.8
All other causes	10.0	3.8	6.2
URBAN.			
All causes	103.3	43.4	59.9
Gastric and intestinal diseases	26.6	2.8	23.8
Respiratory diseases	17.8	2.8	15.0
Malformations	6.1	4.7	1.4
Diseases of early infancy	35.0	28.6	6.4
Syphilis	1.6	.7	1.0
Other communicable diseases	6.8	.5	6.3
All other causes	9.3	3.2	6.1
RURAL.			
All causes	94.4	46.0	48.4
Gastric and intestinal diseases	21.5	3.1	18.3
Respiratory diseases	14.8	3.0	11.8
Malformations	6.9	5.5	1.4
Diseases of early infancy	33.7	28.8	4.9
Syphilis	.6	.3	.4
Other communicable diseases	5.8	.8	5.1
All other causes	11.1	4.6	6.5

Although the total infant mortality rate in rural areas is somewhat lower than the rate in cities, there is no such difference between city and country when the rates from causes directly related to the care and condition of the mother are considered separately.

TABLE VII.—*Infant mortality rates for urban and rural areas in the birth registration area, 1915, by age and cause of death. (Deaths under 1 year per 1,000 live births.)*

Age and cause of death.	Urban.	Rural.	Age and cause of death.	Urban.	Rural.
All causes	103.3	99.4	Other diseases, deaths under 1 month—Cont'd.		
Causes related to the care and condition of the mother:			Other communicable diseases.	.5	.8
Diseases of early infancy	35.0	33.7	All other diseases	3.2	4.6
Malformations	6.1	6.9	Other diseases, deaths after first month:		
Syphilis	1.6	.6	Gastric and intestinal diseases.	23.8	18.3
Other diseases, deaths under 1 month:			Respiratory diseases	15.0	11.8
Gastric and intestinal diseases.	2.8	3.1	Other communicable diseases.	6.3	5.1
Respiratory diseases	2.8	3.0	All other diseases	6.1	6.5

The following analysis of the infant mortality rates in New Zealand offers an interesting comparison with the infant mortality rates of the rural parts of the birth registration area of the United States.

TABLE VIII.—*Infant mortality rates in the rural parts of the birth registration area, United States, 1915, and in New Zealand, 1916, by cause of death. (Deaths under 1 year per 1,000 live births.)*

Cause of death.	Rural United States, 1915.	New Zealand, 1916.
All causes	94.4	50.7
Diseases of early infancy	33.7	20.9
Gastric and intestinal diseases	21.5	5.8
Malformations	6.9	3.8
Respiratory diseases	14.8	4.3
All other diseases	17.5	16.0

TABLE IX.—*Infant mortality rates in the rural parts of the birth registration area, United States, 1915, and in New Zealand, 1916, by age at death. (Deaths under 1 year per per 1,000 live births.)*

Age at death.	Rural United States, 1915.	New Zealand, 1916.
All ages	94.4	50.7
Less than 1 month	46.0	27.0
1 month but less than 1 year	48.4	23.7

5. The findings in the Children's Bureau studies of maternity and infant care in rural counties in Kansas, Montana, North Carolina, and Wisconsin have been analyzed.

The conditions vary greatly. The maternal mortality rate in the United States birth registration area for 1915 was 6.1; for 1916, 6.2 per 1,000 live births. In Kansas, in the area investigated, a rate of 8.6 per 1,000 live births was found, while in the Montana survey, the maternal mortality was 12.7, or over double the average rate for continental United States.

In the Kansas county studied, 95 per cent of the births about which facts were secured were attended by a physician. In one-third (119) of the pregnancies, the mother had some prenatal care.

In the Montana county, 463 mothers were visited. Over one-fifth of these left the area for their confinement. Of the 359 who remained, 230 met the experience of childbirth without skilled assistance—three of these were entirely alone and delivered themselves, 46 were delivered by their husbands, and over one-half were attended by untrained women.

Smaller still was the proportion of mothers delivered by a physician in a rural county in North Carolina.

Even in the two rural districts in Wisconsin, where facts about 614 mothers were secured, over one-third were not attended by a physician at confinement.

Scarcely a mother in any of the rural areas studied had prenatal care measuring up to an accepted standard of adequacy, and more than three-fourths had no advice, on account of the inaccessibility and expense of medical care. In only one of the areas studied (Kansas) were hospital care and trained nursing care available. In none of the areas was a public-health nurse at work.

New Zealand, as is well known, has been successful in securing and maintaining for a considerable term of years lower infant mortality rates than those recorded for any other country. A progressive reduction of the infant death rate has followed the development of work similar to that contemplated by the present bill by the New Zealand Society for the Health of Women and Children and by the Government. These activities are described in one of the early bulletins of the Children's Bureau, a copy of which is submitted herewith.

The chief aims of this society are (1) to uphold the sacredness of the body and the duty of health; (2) to acquire and disseminate accurate information and knowledge on matters affecting the health of women and children; (3) to train specially and to employ qualified nurses whose duty it will be to give gratis to any member of the community desiring such services, sound, reliable instruction, advice, and assistance on matters affecting the health and well-being of women and their children.

The society has more than 80 branches scattered over the country, according to the 1916 report. It issues a book on the care of mother and baby, secures constant and generous cooperation from the press, conducting a baby column in most of the newspapers throughout the country, holds many meetings, has a special hospital in Dunedin where infants who are sick or not flourishing can be cared for and watched until a proper regimen is established for the individual case and the mother fully instructed. Traveling or visiting nurses furnish instruction and actual care. The Government also employs visiting nurses for the remote "back blocks." In some instances these nurses are also responsible for small cottage emergency hospitals at their stations. The Government maintains four maternity hospitals, which are intended to be self-supporting. It also publishes and distributes free of cost books dealing in a practical manner with the hygiene of maternity and infancy. It cooperates effectively with the Society for the Health of Women and Children. Thus throughout this comparatively new pioneer State a fairly complete plan is in operation making available to a preponderating number of the mothers of New Zealand, in country and town alike, health instruction, nursing care, and medical and hospital service.

A comparison of the infant mortality rates for New Zealand with those of the Australian Commonwealth shows the former to have been consistently lower than the latter for each of the five years, 1911 to 1915.

Deaths of infants under 1 year of age to every 1,000 births.

Year.	New Zealand.	Australian Common-wealth.
1911	56.31	68.49
1912	51.22	71.74
1913	59.17	72.21
1914	51.38	71.47
1915	50.05	67.52
Mean of 5 years	53 63	70.29

Though full details as to the care provided for maternity and infancy in the two countries are not available, certain outstanding facts would appear to indicate that the methods employed in New Zealand have a share in causing the differences shown in the table. The Commonwealth of Australia makes an allowance of £5 when a child is born. Notwithstanding the general acceptance of this allowance, it is computed that 36.4 per cent of the births in the last year for which information is avail-

able were not attended by a physician. The report on infant mortality submitted to the Australian parliament in June, 1917, by the committee concerning causes of death and invalidity in the Commonwealth strongly urges the adoption of a general scheme of practical measures, such as are in force in New Zealand and elsewhere, as a means of lessening the infant mortality rate. In August, 1917, the same committee submitted a report on material mortality in childbirth. Figures are given to show that, although there was a decrease in the death rate after the introduction of the maternity bonuses, this decrease was not so great as it had been during the preceding years. The report concluded with the following paragraphs:

"Speaking generally, your committee is of the opinion that much greater benefit could be obtained from the large sum of money spent annually than is being obtained under the present system, and that as the wastage of life and damage to health now occurring in connection with childbearing is due to the ignorance of the mother and lack of skilled care such improvement should be sought in two directions:

"(1) The provision of every facility for pregnant women to obtain skilled advice before the confinement occurs.

"(2) The provision of trained attention by a properly qualified and properly supervised midwife or nurse during the lying-in period.

"The exact method by which the latter of these highly necessary measures is to be accomplished should be a matter for further earnest consideration.

"Information is necessary concerning the causes of illness as well as the causes of death among women during confinement. With the economic aspects of the direct payment to women of cash bonus, your committee is concerned only in so far as the health and lives of the women are affected.

"In the opinion of your committee, however, there is imperative need for the immediate extension of existing facilities for pregnant women to obtain skilled advice concerning their health before their confinement, and the Commonwealth Government might well provide financial assistance to enable women's hospitals and similar institutions to inaugurate or extend such branches of their activity, and might even undertake the provision of such facilities in places where they are as yet nonexistent. The return to the community would almost certainly more than compensate for the expenditure involved."

6. In Canada, the Victorian Order of Nurses, which gives bedside care to the sick and to maternity patients, and which receives a grant from the Dominion Government was founded originally in response to the demand for nursing care made by the farm women of western Canada. This order has established a number of cottage hospitals in small communities, and is developing a plan for rural nursing. Two nurses, living in a nursing home which has accommodations for two or three emergency hospital cases, work in a rural area of about 100 square miles, giving nursing care to the sick and to maternity patients.

The western provinces of Canada—Manitoba, Saskatchewan, and Alberta—are developing plans for rural nursing and hospital work, subsidized by the provincial governments.

The Provinve of Manitoba has developed a system of rural public-health nurses which is financed jointly by the provincial government, the rural municipality, and the local school system. These nurses work in the rural schools and visit every home in their district. Their work is to bring to the rural mothers knowledge of how to keep themselves and their children well. In addition, a system of public-health nursing is being planned, this system to provide bedside care.

The war gave new emphasis to the fact that the protection of maternity and infancy is a public responsibility that can not with safety be evaded by any government. Details concerning the steps taken by the various governments in the early stages of the war are given in a paper on "Infant Welfare Work in War Time," by Dr. Grace L. Meigs, of the Children's Bureau, submitted herewith.

According to that pamphlet:

"In England, practically from the first day of the war extraordinary measures were taken to maintain and increase all means looking to the protection of mothers and babies. The part played by the National Government is perhaps the most salient point in this work.

"It happened that just before the war Parliament was considering a grant to aid local sanitary authorities and voluntary agencies in carrying out such plans for maternal and child welfare as were approved by the local government board. The grants made yearly to such work might amount to one-half of its total expense. In a memorandum bearing the interesting date of July 30, 1914, the local government board gave the details of what such schemes should include, divided into measures for antenatal, natal, and postnatal care. The systematic home visiting of infants and young children was dwelt on, as well as the carrying on of centers for infant and maternal welfare.

Especially emphasized also were the need of coordinating public and private work; the importance of providing proper prenatal and obstetrical care; and the desirability of giving greater attention to the care of the child between infancy and school age."

The report of the local government board for 1917 emphasizes the necessity for increasing the protection of mothers and babies and describes the program now in operation, which is justified by the improved infant mortality figures for the many separate sanitary districts of England and Wales, where with marked uniformity decreases appear for the second year of the war as against the first. The average figures for England and Wales indeed showed an infant mortality rate for 1916 of 91, as against an average yearly rate of 110 for the period from 1911 to 1914. The chief features of the program of the local government board are:

1. The extension of money grants by the local government board to local sanitary districts under carefully specified conditions.
2. The notification of births to the local medical officer of health within 36 hours. (Registration may be made within six weeks.)
3. The establishment of centers for hygiene and medical advice for mother and babies.
4. Provision for proper care at childbirth.
5. Sufficient arrangements for hospital care when necessary.
6. Home visiting by health visitors.

The duties of health visitors are educational as well as practical. Many of the visitors are nurses. It is plain that their work is closely analogous to that of the public health nurses in the United States.

It is of special interest to this country that the program of the local government board covers rural as well as urban areas. As a result of the stimulus supplied by government funds, the local government board could report in March, 1917, that "all the metropolitan boroughs except Camberwell, all the 82 county boroughs except Gateshead, 51 of the 61 county councils outside London, and 360 county districts had some provision for health visiting." Only one important county district remained in which no health visiting had been provided for.

During the months from March, 1914, to February 1917, in spite of the fact that a war-time shortage of doctors and nurses made the work increasingly difficult, the number of health visitors in Great Britain was increased from 600 to 1,024, an average of one health visitor to 800 babies. The number of health centers, which had increased to 842 in February, 1917, reached 1,278 by July, 1918, and the number of mothers and children attending the centers increased in much greater proportion.

The maternity and child welfare act, passed August 1, 1918, widened the power of local authorities in England and Wales by enabling them to make such arrangements as might be sanctioned by the Great Britain Local Government Board for attending to the health of expectant and nursing mothers and of children under 5 years of age. It made available for these new services the Government grant for maternal and infant welfare work (of not exceeding one-half of approved net expenditure) which was first provided in 1914. The act provided for the appointment by the county councils of maternity and child welfare committees, the membership of such committees to include, at least, two women. In its circular the Local Government Board states that it is important that working women should be represented on these committees. The circular gives a list of the services for which the Government grant will be paid to local authorities and to voluntary agencies, and makes suggestions for developing the new services, which cover hospital treatment for children up to 5 years of age, lying-in homes, home helps, provision of food for expectant and nursing mothers and for children under 5 years of age, creches and day nurseries, homes for children of widowed and deserted mothers and for illegitimate children, and experimental work for the health of mothers and children.

7. The aim of infant welfare work is to make available to all mothers opportunity for physical examination, instruction in their diet and general hygiene during pregnancy, and expert advice on the care of their babies in health. From the work that has been developed in many cities in the United States and abroad, a standard method may be broadly stated as follows:

For effective infant welfare work it is necessary to have an adequate staff of well-paid visiting nurses, working under competent medical direction. These nurses must be trained in the principles of public health nursing and qualified to instruct mothers in the hygiene of pregnancy and in the daily care of well babies. Their duties include, also, a systematic effort to make individual mothers realize the importance of physical examinations, the value of trained advice during pregnancy, and the importance of nursing their babies throughout the earlier months of the first year.

Another essential in infant welfare work is one or more consultation centers where mothers may go for advice and for examination by a physician during pregnancy, and to which they may bring well babies to be placed under medical supervision.

Such centers do not give medical or surgical treatment, but refer cases requiring such treatment to the patient's private physician, or to a clinic or hospital. The importance of breast feeding is stressed here, as well as by the nurses who visit the mothers at home. When breast feeding is impossible, or when a baby is old enough to be weaned, the physician at the health center advises the mother about her baby's food, but the actual preparation of food is done at home, where the visiting nurse demonstrates the necessary care and precautions to be observed.

In connection with infant welfare work, it is usually possible and always desirable to carry on educational publicity dealing with the facts of prenatal and infant hygiene and the importance and availability of expert advice and examination. This is done through such channels as a local situation may suggest, but newspaper articles and popular leaflets prepared by experts are universally valuable.

In rural districts, where as yet infant welfare work has scarcely been attempted in spite of the great need, a well-rounded plan would include:

1. Public health nurses who shall be available for instruction and service, as are the public-school teachers and other public officers. These nurses should be especially equipped to recognize the danger signs of pregnancy. The nursing service should center at the county seat or some other accessible point.

2. An accessible conference center for maternal and infant welfare, which will afford opportunity for the medical examination of mothers and of well children, and for medical supervision and advice on matters of health.

3. *Hospital facilities for mothers and children.*—There should be a county maternity hospital or beds in an easily accessible general hospital for the proper care of abnormal cases and of normal cases, when it is convenient for the women to leave their homes for confinement.

4. Skilled attendance at confinement obtainable by every woman in the country.

5. Instruction in the hygiene of maternity, infancy, and childhood, to be made available for all girls and women through different forms of extension teaching.

STATEMENT OF MR. R. S. SEXTON, LEGISLATIVE REPRESENTATIVE, AMERICAN FEDERATION OF LABOR.

Mr. SEXTON. Mr. Chairman, I do not know whether I can add very much to the enlightenment of this committee and, in the presence of the array of what I presume to be expert testimony that will be adduced on this subject later on, whether my statements will be of much value or not, I do not know. But I submit them very gladly in support of this measure.

The American Federation of Labor takes the position that child life is the greatest asset to the Nation and all protection and assistance should be rendered that is possible to protect that life and to assist maternity. This bill provides for that assistance which has been overlooked or ignored or passed up with a degree of indifference heretofore in our country. The American Federation realizes the great importance of assistance of this kind; it realizes that those who are in greatest need of such medical and professional assistance and support, in the hours of child birth and through the years of immaturity of children and during the travail of mothers, that proper safeguards have been greatly neglected. This will provide in a sensible, intelligent, and beneficial way that assistance and insure the lives of mother and child. If we are going to have a great Government, supported by healthy, intelligent people, we must provide for the protection of infant life. This bill, I apprehend, does all of the things that are necessary to carry out that principle, and therefore it is one of the most meritorious bills that has been introduced along those lines. I believe that the committee will be able to see the necessity of it, and recommend its passage, and I express the hope that it will be enacted into law.

The appropriation that is required in order to give the work the proper impetus, that is necessary to start it along right lines, is very nominal and could not be applied in a more beneficial direction than is asked for in this bill.

I am not prepared with statistics to furnish any great degree of enlightenment, but I presume such intelligence will be furnished by those who have looked carefully into the question and have given it greater thought and greater study than I have been able to do. But I am glad to be able to express a word in support of this bill and I am sure when it is given full consideration by Congress that they will see the great necessity of extending Federal support for the protection of maternity, infancy, and the assistance of hygiene for those mothers who are situated in rural districts, and all others that come under the provisions of this bill and are entitled to the assistance and support that this bill provides.

STATEMENT OF MR. BRADFORD KNAPP, STATES RELATIONS SERVICE, UNITED STATES DEPARTMENT OF AGRICULTURE.

Mr. KNAPP. Mr. Chairman, I understand you called me here this morning in order to have me explain what success had been obtained by a similar cooperation between a Federal department and the States for the development of work not only among the farmers but the farm women.

I might say that prior to 1910 the United States Department of Agriculture, while it did a great deal of investigating, did very little work with the women in rural sections, except the publication of bulletins. In 1910, in the Southern States, we began in a very small way an effort to reach the farm women. And knowing very well that that must depend upon a most intimate sympathy and understanding, on the part of the worker, with the women in the country and with the girls, we began in a very small way what we call our canning-club work and gradually extended from that into a very comprehensive work with women. At first, this was financed by the local people themselves and the department in a very small way. In 1914, on May 8, the President signed what you gentlemen probably know as the Smith-Lever Agricultural Extension Act. This act provides for an appropriation, the first year, of $480,000, divided among the States, $10,000 to each State, which the State does not have to offset. It was increased then by sums of $600,000 the first year and increased after that by half a million dollars, and is increasing yearly. But the additional increments must be met by similar appropriation either from the State or from some source within the State. Ultimately, the Smith-Lever total appropriation from the Federal Treasury will be $4,680,000, which must be offset by appropriations from the States or from counties or other sources within the States of $4,100,000.

I may say to you that the act was accepted by every State legislature in the United States, and that up to the present time each increased appropriation or allotment has been met by the States. The total will not be reached until the year 1922–23. The money is distributed among the States, above the $10,000, in proportion to the rural population.

Under that act we have held to the extension system in cooperation with the State, the agricultural colleges of the States, and the counties. In the counties, getting right close to the people, we have what are called the county agricultural agents and what we call the county home demonstration agents; that is, women who are experienced and highly trained in home economics to come in close contact with the people in the county. They have to travel around over the county to meet the needs as best they can.

You might be interested in this map, if you have time to look at it, showing the spread of this work and what it was in January 1, 1919. The yellow spots in the northern territory indicate where the work is not fully organized and one woman is covering a county. I might say to you the reason of the large development in the South is that on account of the relatively low salaries offered, which deterred an earlier beginning, the work did not begin in the Northern States until the beginning of the war in Europe. It was already developed in the South, and we have developed it rapidly to cover all the territory in the South; but being a newer work in the North, it was not developed until after the war began.

In case you desire to ask me any questions regarding the methods of handling our work, I would be glad to answer them.

Mr. NOLAN. Have you any field agents?

Mr. KNAPP. Yes. There are at the present time 1,400 women employed, located in the counties.

Mr. NOLAN. Paid by the Government?

Mr. KNAPP. They are paid only a portion of their salaries by the Government.

Mr. NOLAN. And part by the State?

Mr. KNAPP. Part by the State and part by the county where the work is being done. I know of many counties where more than two-thirds of their salary is paid by the local people from the county government itself. I might say, beyond the offset to the Smith-Lever fund, at the present time there are about $4,000,000 put up from county and other sources to extend this work. Of course, that offsets money appropriated directly by Congress.

Mr. NOLAN. How do you account for the lack of participation by the Northern, Middle West, and Western States?

Mr. KNAPP. The newness of the work.

Mr. NOLAN. As against the activity of the Southern States, it seems to be pretty fully covered there.

Mr. KNAPP. The newness of the work is the main thing. As fast as they get acquainted with it in the North they go ahead, and a number of them just started to put it in last year, 1917.

Mr. ALMON. It commenced in the Southern States first?

Mr. KNAPP. It began in the Southern States first, and then in 1917, in the Northern States.

Mr. NOLAN. Then it is not because of lack of participation and cooperation?

Mr. KNAPP. Not at all. And in three months that map will show a very great difference. The women are interested, but sometimes the home demonstration agents make failures; the agent will go in with the wrong attitude in a county where the women are very proud of the fact they know how to make bread, and she will go in and try to teach them. What they want to do is to answer the needs of the

people and to aid them in what they want to know, how to cure meat or protect eggs, and real problems of that sort; and the work succeeds where the problem touches the interest of the people and not the things they know best how to do. In our work in the South, we have come in close contact with the health problem among the rural people; problems of eradicating flies from the home and keeping out the mosquitoes are some of the things we have had to teach. Some of the first lessons the country women get are lessons in sanitation, teaching them how to can so that the stuff will not spoil but will keep. They get the whole subject of bacteriology put to them in a very practical way, and they learn that they must sterilize the cans and all other implements they handle. In that way they get their first lesson in real sanitation.

Mr. ALMON. Do I understand you are making these suggestions to show what has been done between the National Government in cooperation with the States in that line of work, as tending to support the theory of this bill, that this work provided for by this bill could be carried on to advantage by means of similar cooperation between the Government and the States?

Mr. KNAPP. That is all, just for the purpose of showing what the effect of the support by Congress has been.

Mr. ALMON. From your knowledge of the character of work of which you have supervision, are you of opinion that this cooperation between the national Government and the States, for the line of work intended to be cared for by this bill, would probably meet with the same success?

Mr. KNAPP. Unquestionably. I am not here——

Mr. ALMON. I understand you do not claim to be an expert on this character of work?

Mr. KNAPP. Not at all. And further, I will say I have not had an opportunity to examine the different bills, but the essential thing I am saying is that cooperation between the Federal Government and State activities sharing in the expense within the State, that that cooperative management of the work in the States has brought very great success. And it is bringing success in the administration of the Federal Road Law, as you may know.

Mr. ALMON. Yes.

Mr. KNAPP. I am simply here to testify to the success and the fact that you can approach the rural people with the cooperating machinery of this kind and accomplish the purpose that you have in mind. And I am quite certain that the purposes sought by this bill, which are necessary, can be accomplished by the cooperative machinery.

Miss RANKIN. How do the States respond to this demand for appropriation by the States?

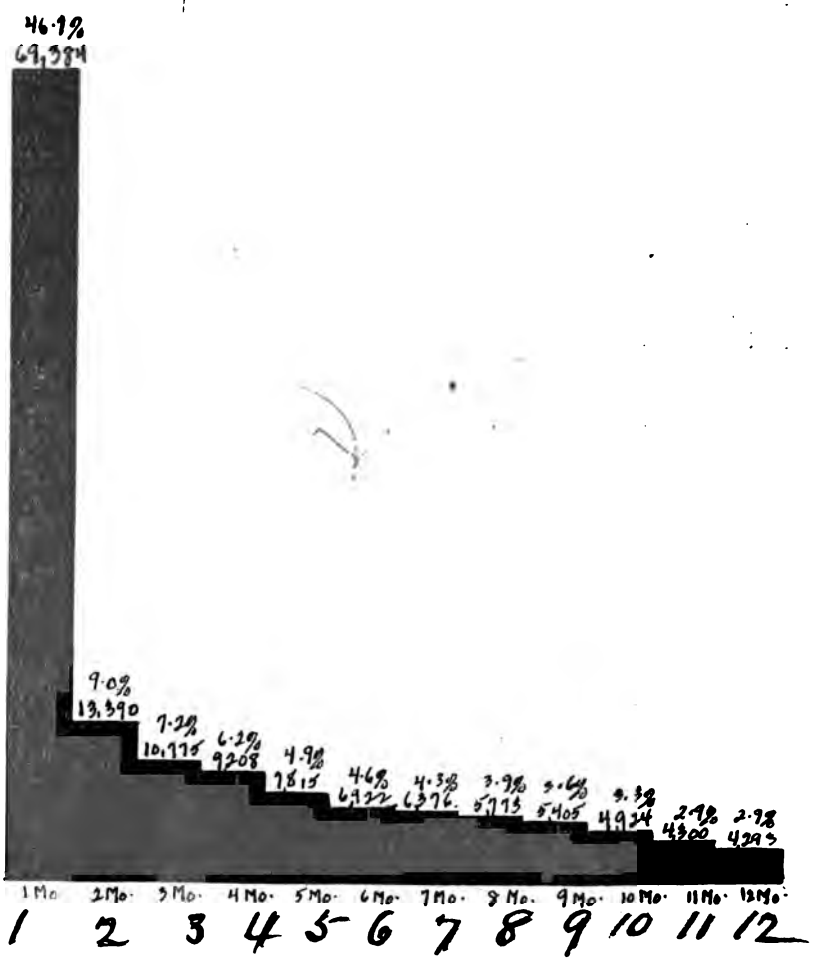
Mr. KNAPP. In the majority of all the States at the pretent time, the appropriation to offset the Smith-Lever fund is made by the legislature in a lump sum to the agricultural college. There are a few States where the taxation situation is such that the State is somewhat poor and where their annual budget is pretty close to the maximum taxing power that they have in the State, where they appropriate some of the money and the rest of it is appropriated bythe counties. That does exist in quite a number of the States, I should say probably about one-fourth of the States.

Mr. ALMON. Mr. Chairman, I want to say that I have some personal knowledge of the work that is being done by this department, over which Dr. Knapp presides, and it has been a great success in Alabama and other Southern States where the work was first introduced, and great credit is due to Dr. Knapp for the continuation of this splendid and most efficient service that was inaugurated by his very able and distinguished father, who was really the originator, in a measure, of this extension work.

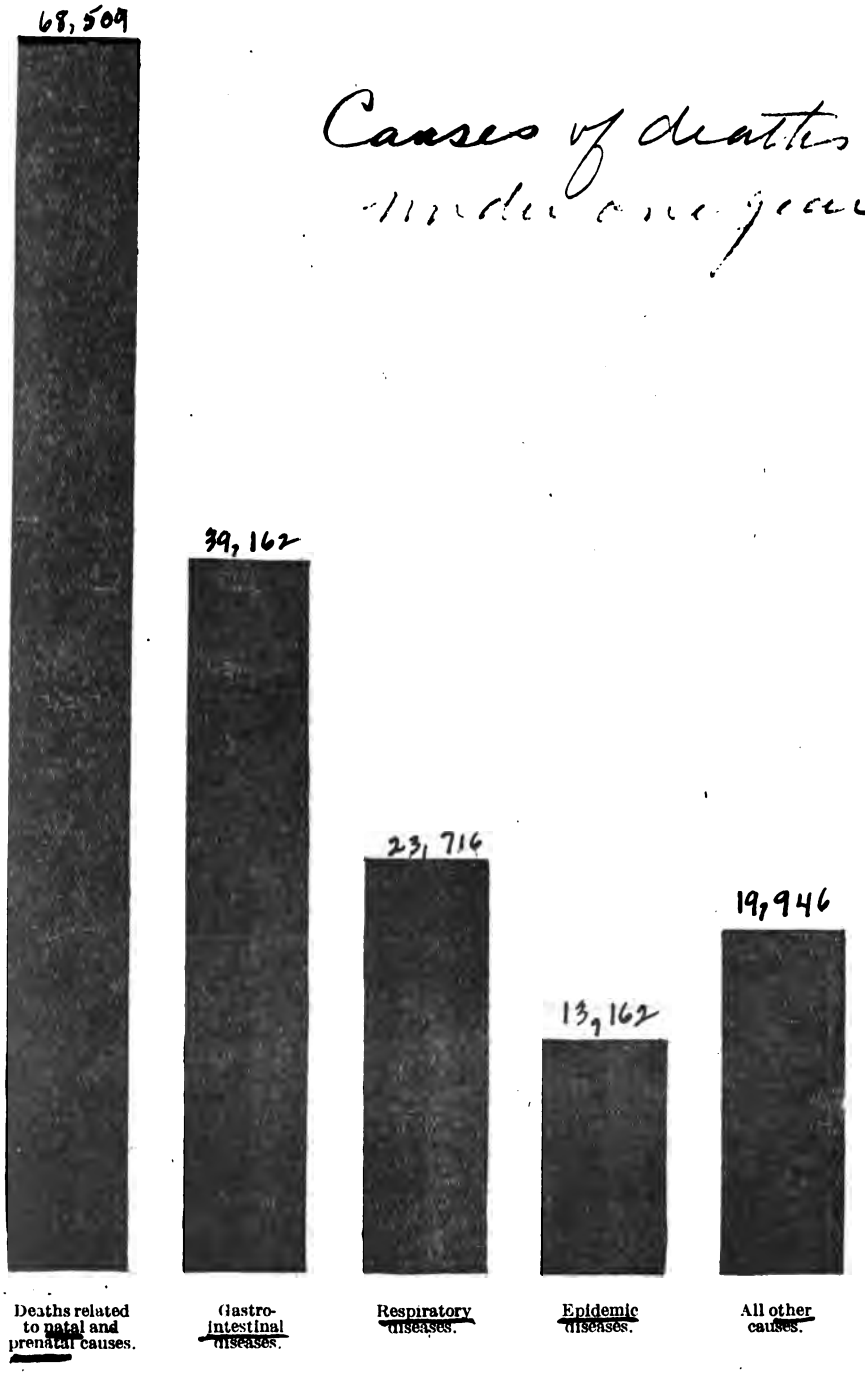
STATEMENT OF MRS. HELEN McCLEARY.

Mrs. MCCLEARY. I am present at the request of Dr. Lee Frankel, of the Public Health Association of America, and at the request of Dr. Josephine E. Baker, of the Society for the Prevention of Infant Mortality. Both of these doctors have big meetings in New York to-day and could not be present, and they have asked me to go on record for them that no action be taken on this bill until the members of those two organizations can be heard. As I understand, they do not wish to oppose the bill, but they wish to present some amendments. The way they understand, the bill now provides for the development and organization of the work without in any way considering the State organizations, and there are some States which have organizations at the present time that might do a big work, and in other States they desire to suggest amendments where they can cooperate and coordinate the work.

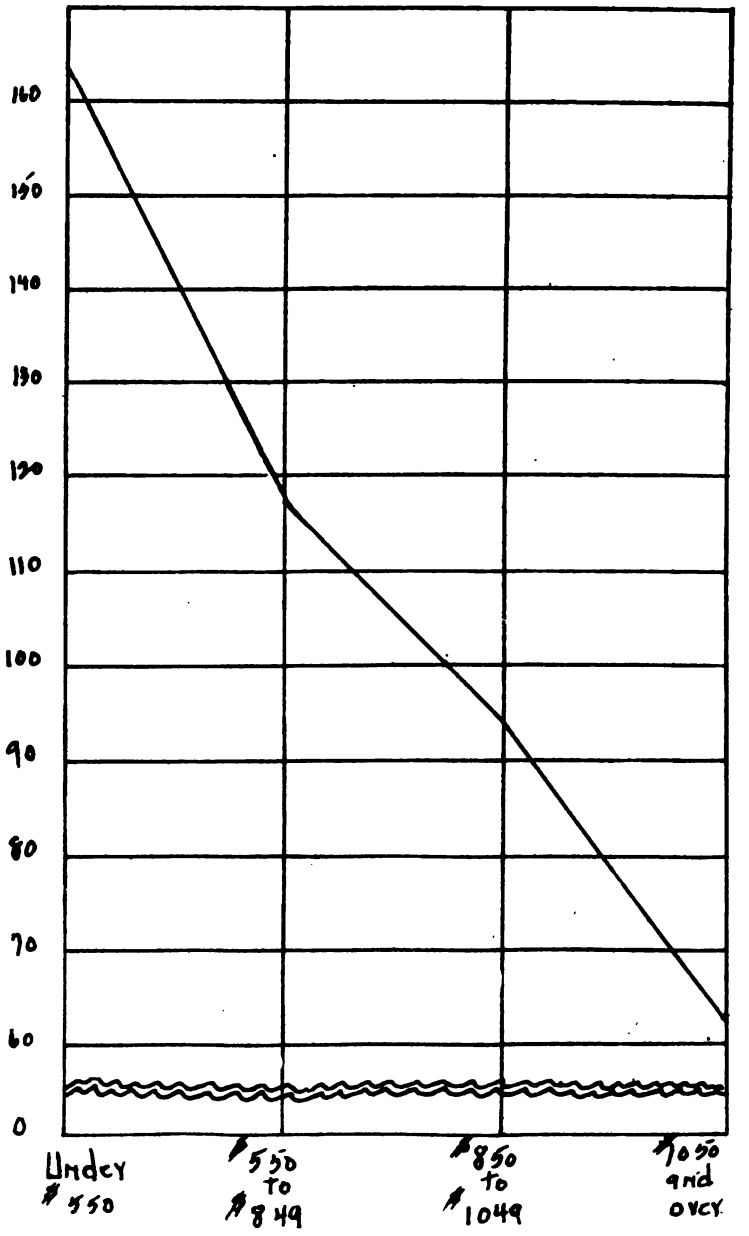
Deaths under one year by monthly age group.
(United States registration area, 1915.)



Deaths under one year grouped by cause.
(United States Death Registration Area, 1916.)

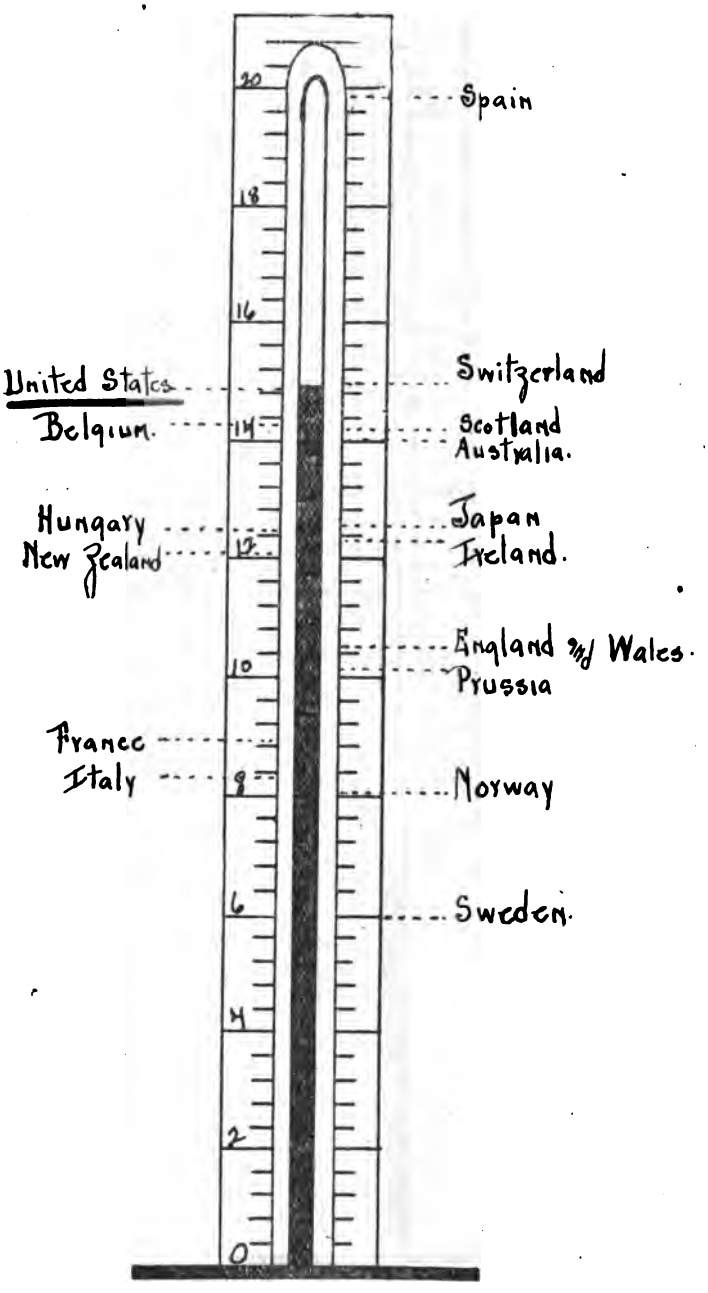


Combined infant mortality rates for 8 cities according to father's earnings.

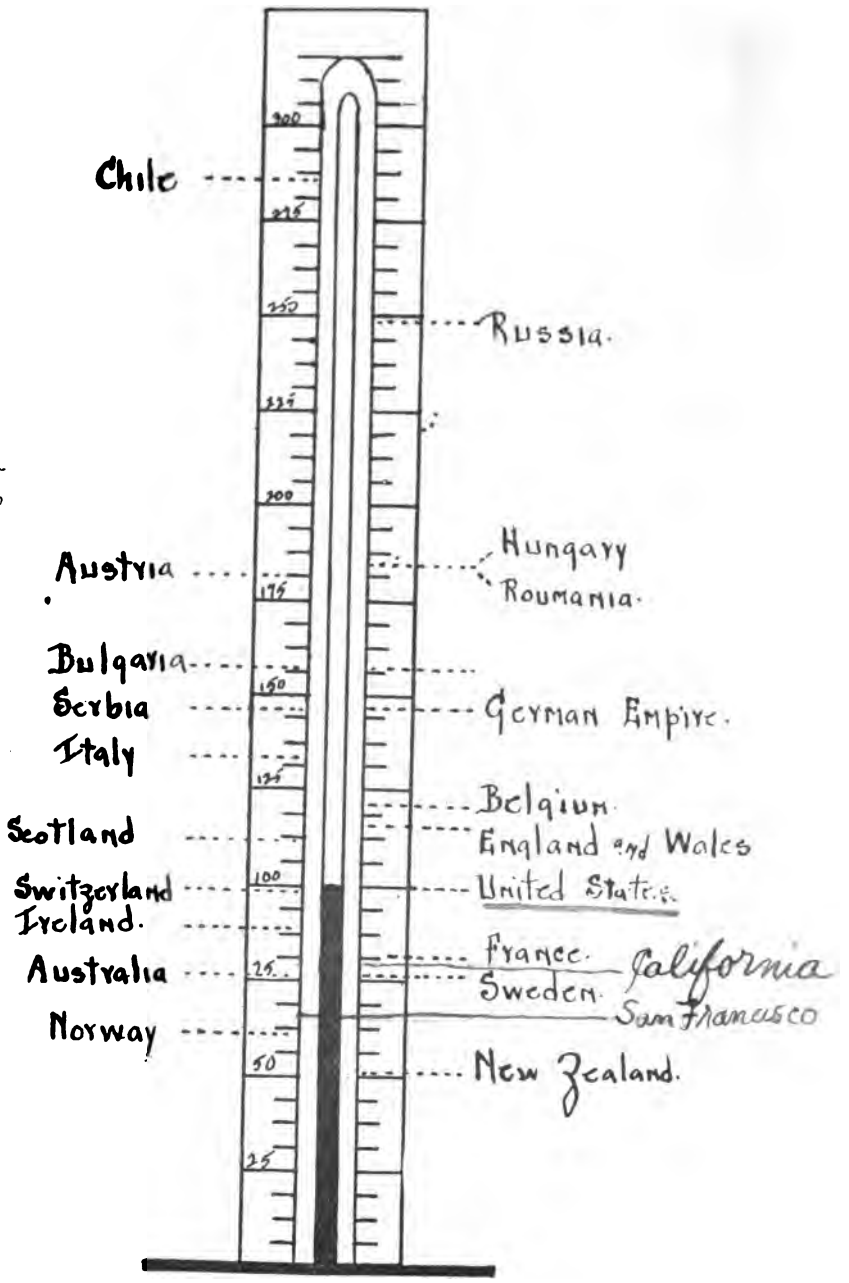


~~Maternal mortality thermometer for the world~~

~~(Death rate per 100,000 population.)~~

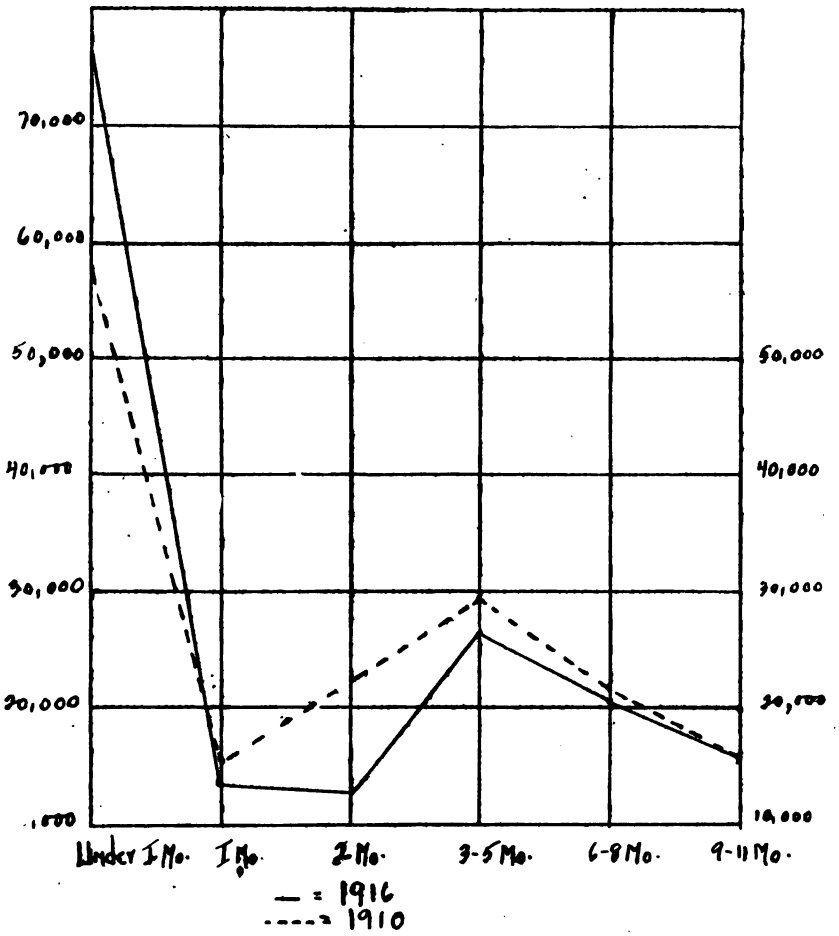


Infant mortality thermometer for the world.



Deaths of infants by months—1910 and 1916.

(United States death registration area, 1910–1916.)



STATEMENT OF DR. DOROTHY REED MENDENHALL, OF WISCONSIN.

Dr. MENDENHALL. I am from Wisconsin and have done public health work in that State. In section 5 of the brief you will find a statement of rural maternity conditions, which I think is as accurate as can be made at the present moment. The reporting of births and deaths from the rural districts is so poor that many of us believe, and I am one of them, that the death rate probably is actually greater than the returns now show. The death rates in rural districts are greater in the United States than we appreciate. The percentage of deaths the first month of life is greater in the country than it is in the cities, but if a child survives birth, and does not die the first month of life, it probably has a better chance for life in the country than in the city.

I was asked to speak on my personal observations regarding the success of extension work in Wisconsin, and also to give you an idea of the survey made in Wisconsin in 1916 by the Children's Bureau.

About six years ago the extension division of the University of Wisconsin put into its curriculum the teaching of the hygiene and care of the child, particularly the infant, because there was a great need and demand for such instruction from mothers in rural districts. The first thing that impressed us when we went out to give these talks on the child was that when the mothers came up to talk with us afterwards, or we had a conference with them on the streets, or in the hotels, as we often did, the questions asked us were almost purely obstetrical. They asked us what caused miscarriage, why the baby died at birth, and why they could not breast-feed the baby.

We went back to the university and reported this interest and asked to be allowed to give talks on maternity. Our request was granted, and this part of our health program has met with great interest and appreciation. Many women have felt that these talks gave them definite knowledge, which they had not previously had, about the proper care of themselves during pregnancy, and the need for medical attention and rest during the lying-in period. The university at this time also put out popular correspondence courses on the care of the prospective mother and the care of the child. The course for the mother has been taken not only in Wisconsin, but also in many other States all over the United States, especially in the rural districts. Unfortunately, such courses cost $4. The university extension has to be supported, and these correspondence courses furnish one means of support. It seemed to me to be a great pity at the time, and I protested that such a course ought to be free, because many of the women who needed it most could not afford to pay for such instruction.

Three years ago I started on agricultural extension work under the Smith-Lever act. Although it was not fully organized until 1917, the appropriation had already been given the State, and in Wisconsin health talks were featured at the meetings held for women in rural communities and in small towns. We often went to small towns, 25 miles from a railroad. At these meetings, talks on maternity, on infant hygiene, and the care of the older child are given, after which the children are examined and the mothers advised as to their health and the care they should give their children.

I remember one woman drove in an open sleigh for 25 miles to hear our talks on the care of the mother and her child. She brought her five children with her, one a baby, because she said she had never been able to have a physician see them before, and she had a great desire to know if her children were perfectly healthy.

Many problems were presented to us at these conferences. I remember one particularly interesting case of a harelip, a case where the local physician, who happened to be ignorant, had told the mother that harelip children never survive and the only thing to do was to let her child die. This mother came to us, and we were able to tell her how she could save it, how she could pump her own milk and feed it to the baby, and we also advised her where to go later for the necessary operation. When we went back to that village after a period of two years we found that the child had been operated on and was apparently perfectly healthy and normal. I could cite many such instances. Certainly the work was well worth while, and the women showed the greatest interest and enthusiasm. We made it our business to study the care of maternity in these communities. One of the questions we asked at every meeting was how soon the women got up to do the family washing, for we soon found out there was no use in asking how long they stayed in bed after confinement, for many of these women have to do some part of the domestic work after only a few days' rest. I do not think there was any audience where half a dozen hands did not go up when the question was asked if any of them did the family washing before the second week after delivery. As one woman said, "What is the use of waiting until the second week, because then you only have two weeks' washing to do instead of one."

These conferences made us realize how many women have only the help of some member of the family at childbirth, or rely on the help of a neighbor woman at this time. The dearth of domestic help and nursing care are serious obstacles to improving rural conditions.

In Wisconsin, in 1915, an analysis of the birth and death certificates showed a low total death rate, as well as a low infant mortality rate and a high percentage of deaths the first month of life. The rural districts showed a much higher percentage of deaths at birth and the first month of life than was found in the cities. As one of our workers said, "If you can survive the first weeks of life, the country is a good place to be born in."

The findings of the Children's Bureau in the survey made by them in Wisconsin in 1916 explain many things we have found to be true and corroborated our observations. From extension work and from the experience of the State board of health, two counties seemed to present quite typical rural conditions. The Children's Bureau conducted partial surveys in these two counties, one a southern, more prosperous, and earlier settled county, and ane a much larger northern county, where the people are just emerging from pioneer conditions.

In this northern area the land is being cleared, farming is just beginning, and there is evidence of considerable ignorance and poverty. This county has a high percentage of German and Polish settlers. The Children's Bureau's investigations in certain parts of this northern county covered the details of 486 confinements, occurring during the previous two years. The facts obtained from talking to these mothers show why in Wisconsin the percentage that deaths the first month after birth form of all infant deaths is 10 per cent higher in the rural districts than in our cities.

The reason for this bad showing of rural communities can be found in unavoidable hardships or in ignorance. First, under hardships, we must consider work. In the county in the northern part of the State, in one township, which is typical of this county, nine-tenths of the people are farmers, and one-tenth of them are tenant farmers. One-half of the farms are mortgaged, and often the men work out as day laborers, away from their own farm, to help pay off the mortgage. The women have no domestic help, they have large families, and besides their heavy house duties, they share and share alike with the men in all the farm work.

One story, which could be duplicated many times will give an idea of their life. A Polish woman and her husband moved on a "forty," and they had only 5 acres cleared. They had two small children when they took this section, and the man went out as a day laborer in order to help pay for it. The woman did all the farm work, milked two cows, pitched the hay, cut the wood and piled it, and dug the potatoes and stored them for the winter. The fall that they moved on the farm she had her third baby. She stayed in bed two or three days at this time, the man doing the farm work and the housework, and the midwife they employed doing the family washing. At the end of the first week after the third baby was born, she had resumed all of her farm duties. Within the next year she had her fourth child. At this time she stayed in bed a week, because she had a fall just before the child was born, and she felt she needed extra rest, so she did not resume her farm work of hauling the wood, pitching hay, etc., until two weeks after the birth of the child. When the fourth child was 2 months old, the father went to Milwaukee, because he could get higher wages in the city and the mother stayed on the farm alone, with the four children, the oldest under 5, with no one to help her do the work inside or outside of the house. That was a Polish family, but I am sorry to tell you there are American-born women doing practically the same thing in Wisconsin to-day.

Now you will realize what I mean by hard work being a factor in rural health conditions.

The second hardship is dearth of doctors and inaccessibility to hospitals. In this northern county, 55 miles long by 30 miles wide, there are only two hospitals, other than the county poorhouse. One hospital has 60 beds and the other 16; both are at the county seat. A sick woman would probably have to travel many miles over the worst roads you ever saw, and possibly several hours by train in order to get to a hospital. So inaccessibility to hospitals and bad roads are hardships that rural communities endure.

Badly trained attendants is another factor to be considered in the country. Only 58 per cent of the women in the survey were confined by doctors; 36 per cent were confined by midwives, and 6 per cent by others—the neighbors and members of the family. The midwives investigated were 14 in number. Only two of these had had any training at all, and only two, the two who had had the training, had license to practice in Wisconsin. So the others were really working illegally and without any training.

Another hardship, as I mentioned before, is the lack of any available domestic or nursing service in these places. Of 486 confinements in this county, one-fourth of them had no nursing service whatever during confinement. Including the midwife service, three-fourths of

them were taken care of by "folks," as they put it, that is by the neighbor women or by their own people.

The second factor in rural health problems is the question of ignorance. In regard to maternity, the fathers and mothers are absolutely ignorant of the prenatal care that a woman needs at this time—that she should be under a physician's care throughout pregnancy. As a result, only one-fifth of the 486 pregnancies had had any medical supervision, and only two of the 486 had what we call minimum adequate prenatal care using the standard of Dr. J. Whitridge Williams. Worse than the lack of prenatal care was the absence of skilled attendants at confinement. These families do not realize that it is important to have medical attendants at confinement. One man whose wife was sick during pregnancy sent 25 miles for a doctor in midwinter, in order that she might have a real doctor. He would not take the physician living only 8 miles away, who did not have a very good reputation and probably was not a fully qualified physician. He said, "When you gets somethin' for protection"—protection in this case being the doctor—"you wants the best there is." When his wife was confined three months later, he had the local unlicensed midwife of the place. He did not realize that confinement required the services of a skilled physician.

As a result of th s investigation, which I have described very briefly to you, we found in this county an infant mortality rate of 115. The average rate for the Un ted States was under 100 for this same year, 1915. We also found a high maternity death rate. Incidentally, this county has one of the worst reputations for chi d-bed fever of any county in the State; it had one of the highest averages over a seven-year period, that is, more cases compared to the number of confinements. This is a striking demonstration of what follows lack of prenatal and obstetrical care.

The three points I should ike to make in closing are these: In the first place, something should be done to enl ghten the ignorant public, the fathers and mothers, in regard to the necessity for prenatal care and skilled assistance at confinement and rest during the lying-in period. Secondly, the relation prenatal care and skilled assistance at confinement and rest during the ly ng-in period bears to the children we lose at birth should be convincingly demonstrated. Half of our infants dying during the first year after birth die during the first six weeks of life. Most of these children are born too weak, to ignorant, or too diseased to live. Besides this huge loss of life the first weeks after birth, many infants die during the first year from premature weaning, because the mothers do not nurse them, not having had the proper care and food during the lying-in and nursing periods. The third point is that, in the rural districts, it is absolutely impossible, so far as I can see, for women of the class I have described to you, to have prenatal supervision and adequate, skilled assistance at the time of confinement, unless some measures such as this bill affords are taken.

Mr. ZIHLMAN. You have a local organization which could be made available under this appropriation?

Dr. MENDENHALL. We have the State board of health and the university and agricultural extension services, which work in cooperation with the Children s Bureau, and distribute its publications. The survey of the Children's Bureau in the State was made at our

request, so that we might have absolute evidence that these conditions just described were true.

Mr. NOLAN. If we were going to grant Federal aid to the States, why confine it to the rural districts; why not give the cities, like Milwaukee, Racine, Detroit, and other large industrial centers up there, some of the benefits of this Federal aid? Is there any particular reason why we should discriminate?

Dr. MENDENHALL. Of course there is this one reason: This is for the rural districts, and "rural districts" includes everything under 10,000; so it is not absolutely the open country you are dealing with. All of the large cities have hospitals, have dispensaries, and have good physicians; they have clinics and centers and settlements under different organizations which are now working for the benefit of maternity and infancy.

Mr. NOLAN. Why not leave that to the States? Why not say this money should be used at the State's discretion; why confine it specifically to the rural districts? Why not leave that to the States: give them the aid and leave them to determine where the money shall be spent?

Dr. MENDENHALL. I think we feel that the rural districts need it most. The rural districts are less able to speak for themselves. I should be a little afraid of some of our big cities with their powerful organizations; if there were any funds to be obtained, they might obtain them and leave very little for the country.

Mr. NOLAN. Why could we not safeguard that, as it is in a way safeguarded in here; because it must be spent to some extent under the supervision of the Children's Bureau of the Department of Labor?

Dr. MENDENHALL. That possibly would safeguard the rural interests. I have not thought of that point. I think we know the greatest need for better care of mothers and children is in the rural districts, and nothing has been started there. There must be Federal aid to stimulate State activity. I do not think many of the States have as yet appreciated the fact of this great need.

Mr. NOLAN. But I want somebody to explain to me, if they can, why there is any particular reason for providing a new method for assisting in preventing infant mortality in this country, for confining Federal money to the rural districts.

Dr. MENDENHALL. I suppose the Smith-Lever money is confined to the rural districts.

Mr. NOLAN. But we are raising babies in the cities as well as in the rural districts. I do not have any objections to the Smith-Lever bill; I voted for it because I believed in agricultural extension work and I believed the publications of the Department of Agriculture could give all the information to home gardeners which they desired, through bulletins. But I do not believe information can be given in that way regarding prenatal care of women, although the Children's Bureau has distributed some very valuable publications, but it is not in intimate touch with mothers and children. I can not see why you want to discriminate, or anybody wants to discriminate between the city and the country.

Dr. MENDENHALL. All we want to do is to see that the work in the country is started.

Mr. NOLAN. I have not any objections to legislation; the question of the smallness of the appropriation does not appeal to me as a reason. And I want somebody who has had this experience to give this committee the reason for it.

Mr. VAN DYKE. As a matter of fact, this is already started in most cities, is it not?

Dr. MENDENHALL. The very large cities have started such work, and they have the available aid for the mother; she can get instruction and skilled assistance and can go to a hospital and have rest during the lying-in period.

Mr. NOLAN. The fact of the matter is they do not do it; I think you will find in your investigations that they do not go to the hospitals.

Dr. MENDENHALL. Our hospitals are pretty full.

Mr. NOLAN. A great many women do not want to go to the free hospitals, and the others they can not afford.

Dr. MENDENHALL. That is just a matter of education. France in 1915 showed what education can accomplish. In Paris just 5 per cent of the women confined were delivered outside of hospitals or without medical service sent out from maternity hospitals.

STATEMENT OF DR. ANNA E. RUDE, DIRECTOR, DIVISION OF HYGIENE, CHILDREN'S BUREAU.

Dr. RUDE. I think most of the points have been pretty well gone over, but I do want to impress upon you how, from the very first, the Children's Bureau has been largely governed by existing conditions.

Back in 1912, when it was known that there was to be a Federal Children's Bureau, before there were even any plans for organization made, letters began pouring in from all over the country. Those letters from mothers regarding the care of themselves or their children were a large deciding factor in the Children's Bureau undertaking as its first work studies in infant mortality.

As most of you no doubt know, the Children's Bureau has made eight urban infant mortality studies and an analysis of the resulting figures. As soon as you begin to analyze those figures you note the large number of children who die from causes relating to conditions of the mother during pregnancy or at confinement. The next logical step after these studies was an investigation of conditions relating to maternal mortality. The bureau did this first by a statistical study, taking the figures from the census (the only available figures). At that time 15,000 mothers died annually in this country from conditions relating to childbirth. The 1916 census figures are even worse; they are 16,000.

The number of letters which came in from rural localities, particularly regarding prenatal matters, was the deciding element as to the subject of the bureau's first publication, published in 1913, Prenatal Care. Since that time some 500,000 copies of Prenatal Care have been distributed, and there is still a constant demand for the bulletin from rural districts.

To illustrate, one letter came in from a woman who was 65 miles from a doctor or nurse, telling with what horror and dread she was

anticipating her confinement, because she had witnessed for years the tragedies which had taken place on the surrounding farms because mothers had had to depend entirely upon the experience of neighbors for any sort of help during confinement. In response to the many letters from rural mothers and because of the fact that three-fifths of our child population is harbored in rural localities, the bureau felt that it must undetake a study of rural conditions.

The Children's Bureau has made studies and done work in nine different States. I have had the invaluable experience of doing work in rural localities in two of the western grazing States and also in one of the Southern States. The appalling conditions which one finds are really due to ignorance of the dangers that are attendant upon childbirth.

In our rural studies we have held, in connection with the surveys, children's health conferences where the people could bring their children and have them examined by a Government doctor and be told of their physical condition and given advice as to their care. The eagerness with which people respond makes one realize the necessity of the Government's giving assistance. In one of our most primitive homestead States, where the conference center was a hundred miles from the railroad and people had to drive 20 and 30 miles to the conference center, we had a 100 per cent attendance; that is, every family who had young children to be examined brought them to the conference center. I remember one mother who had got up at 4 o'clock in the morning of the day before the conference and had started to drive 25 miles over very rough roads. A blizzard had come up during the day, and several times she was compelled to stop at farm houses along the way to thaw out. She remained in the locality of the conference center over night, and the next morning was the first to arrive, bringing one child 2 years old and another 5 and a 2-months-old baby swaddled in blankets.

I am very glad to tell you that as a result of the work we did in that county the board of supervisors in the following spring purchased a Ford for the use of a public health nurse whom they have since secured.

In another one of the western grazing States, where we made an intensive study, data were gathered regarding 463 births. That was in one-half the county. The conditions found therd there were that one-fourth of the mothers left that area for their confinements, going more than 100 miles to the nearest hospital. That is a very small proportion, for the reason that such great expense is entailed that the average homesteader in such a locality can not afford it. The people make their living on their farms, but they have no ready money. Very recently another case has come to our attention where the father has had to leave his home and take a position with the railroad in order to get cash enough to enable him to take his child 100 miles to the nearest hospital for an operation for a congenital foot deformity. I simply cite these cases to show you that in remote rural areas people have no money with which to pay for expensive care of any kind. Out of this same group of mothers there were 230 who had experienced childbirth without any competent medical care whatever; 46 had been delivered by their husbands and 3 women were entirely alone. I recall very vividly a young 18-year-old mother, who told us of having been alone during the three days following the

birth of her first child, because her husband was out hunting cattle at the time, which was in the dead of winter.

In the Southern States we have made many more studies; there we find that prenatal care is quite as lacking as in other localities. There were fewer women, if anything, confined by physicians. Another very startling fact which records of children revealed was the lack of medical attendance. For example, more than half of the children under 5 years of age who had died within the past two years in that county had had no medical attention whatever. The certificate was signed simply "No attendant." That, of course, has to be attributed absolutely to ignorance. Ignorance in this county did not preclude poverty; not at all. It was a thrifty, prosperous county, with no poor people in it. I wish you to realize that we find ignorance among the well to do as well as among the poor. In cities, however, and in many other localities the well to do usually protect themselves from their own ignorance by their ability to employ skilled help.

In the South we found that the response from the colored people was quite as great as from the white people. We held conferences in the white school houses in the afternoon and in a colored church in the evening. The darkies would come and sit around a warm fire, very often singing, and I remember one occasion when we examined pickaninnies until 2 a. m., because the parents came to stay until every child had been examined. You do get the response if you have something to offer.

Our studies show very clearly that the cost of work in rural localities is so very much greater than in urban localities, because of a scattered population; that the funds are less; and that where there is the most need for work the people are less able to meet it financially.

We have to take the reports of what is already being done in the cities to show us what can be done; there our studies furnish absolute proof of what we can do in rural districts. When you realize that the last census figures, 1916, show that we are losing annually 16,000 mothers, that in that same year we had an annual death rate of 230,000 children under 1 year of age, and when we definitely know that we can prevent one-half this loss of life, we do know that we need some Federal assistance by which this can be accomplished.

One more point. The Children's Bureau was assigned by Congress in the act establishing it the whole field of child-welfare work, and by its studies in infant-welfare and prenatal work and obstetrical care for mothers, as well as because of the knowledge it has of the actual conditions existing in many types of rural districts in many parts of this country, it has been ably prepared for the task of making plans for the carrying out of this Federal measure for the protection of maternity and infancy.

The question that has arisen regarding the child-hygiene divisions I should like to answer. To begin with, we have at the present time only 11 States which have divisions of child hygiene. Six of these have been organized during 1918, and the Children's Bureau has very generously been given the credit for having stimulated this work through its children's year campaign, which was a war-time drive during this past year. With six new divisions not yet organized for work, that leaves only five States which have had State divisions of hygiene for any time appreciable, and several of these continually

handicapped by lack of funds. Others are so feebly organized as to be doing very little State-wide work. It seems to me very logical to have a director of the division of child hygiene in each State having such a division under the State department of health, as the person who would be appointed to represent the State board of health on this new maternity and infancy board.

Mr. NOLAN. Have you been connected with the Children's Bureau since its inception?

Dr. RUDE. No, I have not. Last year I did field work for the bureau and have been in my present position since July 1, 1918.

Mr. NOLAN. Were you connected with it when it made an investigation in Johnstown; I believe that was one of the first?

Dr. RUDE. No; I was not.

Mr. NOLAN. Have you ever made any investigation of the large cities since you have been connected with the bureau?

Dr. RUDE. No; not since I have been connected with the bureau.

Mr. NOLAN. Do you know whether the result of those investigations has awakened the local authorities or the State authorities so that they themselves put into effect any efficient organization in those particular cities, or States, or localities, to take care of this work along the lines suggested by the Children's Bureau.

Dr. RUDE. Wherever a survey or study has been made, it has been very stimulating. We get letters and reports from those different cities stating what has been accomplished; milk stations have been established or infant welfare centers or other welfare organizations, which date back to our work.

Mr. NOLAN. Have they put in organizations molded along the lines suggested by the Children's Bureau of the Department of Labor specialists who are particularly well qualified to take care of the work in the community? Do you know of anything like that?

Dr. RUDE. I could not answer that. Usually of course they have to avail themselves of local material. I think the important effect is the stimulation.

Mr. NOLAN. Has the Children's Bureau made any second surveys after a period of time to see what results have been accomplished?

Dr. RUDE. I think somebody who has been connected with the bureau longer than I have been might be able to answer that.

Miss FLEMING. I think Miss Lundberg can answer that.

Miss LUNDBERG. I can not answer along that line; we have not made any studies that far back.

Mr. NOLAN. You made an investigation pretty nearly six years ago in Johnstown.

Miss LUNDBERG. The bureau has kept in touch with the Johnstown conditions through correspondence and through information from the local people.

Mr. NOLAN. Have they themselves benefited and profited by it?

Miss LUNDBERG. We feel they have by the reports we have. It is very difficult to credit any definite thing.

Mr. NOLAN. It seems to me the bureau itself might attack that matter and see whether the result of their investigation in a locality after a period of years, would be beneficial, to see whether the infant mortality in that section might be reduced.

Dr. RUDE. That is one of the unfortunate things about Government work. I know I have felt when leaving a community that I should like to be able to do some follow-up work.

Mr. NOLAN. Of course the expense involved would be so much less in getting the statistics as to the cause of death, and so forth, than the first investigation would be, that I think it would be worth while.

Miss LUNDBERG. I think Mrs. Gaffney can give you the figures and definite facts.

STATEMENT OF MRS. MATTHEW PAGE GAFFNEY, CHILDREN'S BUREAU.

Mrs. GAFFNEY. The Johnstown infant mortality rate showed an unusually large reduction as compared with other cities in Pennsylvania in the years immediately succeeding the investigation of the bureau there. An infant mortality committee was appointed by the chamber of commerce, as is recorded in the third annual report of the Children's Bureau. Various reports from Johnstown indicate that great interest in children's welfare was aroused by the study, which was expressed in many permanent forms, such as the securing of infant welfare nurses, a baby welfare station, an improved milk supply, and in renewed effort for a complete sewerage system.

Mr. NOLAN. I was interested in finding out what benefit from the unfavorable publicity given a city of that kind would be.

STATEMENT OF MRS. FLORENCE KELLEY, GENERAL SECRETARY OF THE NATIONAL CONSUMERS' LEAGUE.

Mrs. KELLEY. I speak as the secretary of the National Consumers' League, of which Secretary Baker is the president. In the service of that organization I have had occasion to live in the most congested industrial centers in two great cities—the first four years at Hull House, Chicago, and afterwards at the Nurses' Settlement on the east side of New York City. I have been much impressed by the fact that in the reduction of infant mortality, which I have watched at close quarters, it is the children of the aliens for the most part whose lives are saved. It is the alien mothers, the newly arrived strangers, whose appeal to pity has led to the creation of great nursing associations, so that large numbers of them have more skilled care both at birth and also for illness in their families than the better situated native American working-class families in the same city. And as I travel through the country I find the forgotten children and the forgotten mothers are in large part the Americans, the native women, the old stock people, who are living a rural life. Particularly is this true in the South; it is also true in the Northwest and in New England. All over New England there is admirable visiting nursing and hospital care in the cities for foreigners, but not in the country. For instance, where I have spent my summers for many years, in one of the counties of Maine, we find Uncle Sam caring most solicitously for the young lobsters; our waters have fresh supplies of young lobsters at intervals of three years; but the American mothers there must depend for assistance on their rural neighbors. The number of children born is very small, indeed, and the death rate of the newly born is appalling. It is remarkable that Uncle Sam should care so much for the young lobsters and so little for the American children.

I talked with the Chief of the Children's Bureau about this bill before she sailed. She wished it made clear that, if the question arose, there is no conceivable objection to having cities embraced within the scope of this bill. The word "rural" was put in for two reasons: First, because Uncle Sam seemed to be more completely oblivious of his rural children than of the urban ones. In the cities we have various agencies of assistance, educational and others, and we have just recently had a crusade carried on by the Federal Government to assure, as far as it is possible by its intervention, that the children born in the future shall be free from taints which have affected children in the past. But rural folk on the whole have been meagerly treated. In the second place, it was thought that inasmuch as the Government had never done anything along this line for mothers and babies before, it might continue to be niggardly, as it was at first with the Children's Bureau. The Children's Bureau started with a pitiful, paltry sum of $25,000.

There is no conceivable objection to as generous an appropriation as Congress may be moved to give to take care of all children in the cities as well as in the country districts. I know there will be no opposition to that.

Coming from New York, and having seen the admirable work of Dr. Josephine Baker, of the New York City Department of Health, for the alien children there, I wish to go on record and express my astonishment at the absence of both Dr. Baker and the president of the American Public Health Association, Dr. Frankel, who is also the head of the greatest funeral insurance company that has ever existed anywhere on this planet. I can not conceive of any public meeting that could occur to-day more important than this hearing.

May I add to what I said before in relation to Mr. Nolan's question? I think the work of the Children's Bureau in those cities where they have studied infant mortality has resulted in ways quite unforeseen and is of even national significance: and that we shall be able to go back to those cities at the end of 10 years and show what the stimulus of the investigation did for them. I know from Miss Lathrop that numbers of cities have asked to have investigations made, and they have had to be refused where they were not within the registration area, because the material for study was not available. It is indispensable for finding out how many children die of a thousand born that records should be kept both of the children who are born and the children who die. The impetus toward starting birth registers and death registers in the States which are not urban has been a most significant result of these inquiries.

COMMITTEE ON LABOR,
HOUSE OF REPRESENTATIVES,
Tuesday, January 28, 1919.

The committee met at 10.15 o'clock, a. m., Hon. Jeff. McLemore (acting chairman) presiding.

There were also present Representatives Almon, Robinson, Hersey, Zihlman, and Miss Jeannette Rankin.

Mr. MCLEMORE. I believe there is a Mr. Frankel wishes to be heard.

Mr. FRANKEL. Dr. Baker wishes to be heard first.

Mr. MCLEMORE. All right. We will hear Dr. Baker.

STATEMENT OF S. JOSEPHINE BAKER, D. P. H., PRESIDENT, AMERICAN CHILD HYGIENE ASSOCIATION.

Dr. BAKER. Mr. Chairman, I am appearing here in my capacity as president of the American Child Hygiene Association, which has a membership of about 1,200 people who are interested in child welfare movements. These members come from 41 States of the Union, and there is also a small membership from the other American countries. At a meeting of the executive committee of our association held last week, I was instructed to appear before your committee, if possible, in regard to House bill 12634.

Mr. FRANKEL. Mine is Senate bill 4782. I think it is the same bill.

Dr. BAKER. The American Child Hygiene Association wishes to place itself on record as favoring the purpose of this bill. It believes that the extension of maternity and infant welfare nursing is a matter of fundamental and vital importance to the welfare of the people of the United States. It wishes, however, to register a protest against the machinery of this bill. In order that there may be no misunderstanding as to the lateness of our protest, may I say that in July I brought this matter to the attention of the Chief of the Children's Bureau, regarding just this protest against the machinery of the bill, and have an answer from the Chief of the Children's Bureau to the effect that she considered my position a strong one and felt that the bill could be amended. Since that time nothing has been heard from the bill until the notice was received for the hearing, as far as I am concerned.

Our position is that it is fundamentally and basically wrong to create in each State a new board to care for this work when there is in each State of the Union, actually or potentially, a board of health with its own machinery and power and legal authority to carry out all the functions of this bill; that in 11 States of the Union there are already established divisions of child hygiene whose main purpose is the care of infancy and infant welfare, and nursing; that if this bill is passed and a new board created in each State to care for this work it will tend in effect to wipe out these divisions. Practically all present divisions of child hygiene have started with infant welfare work. If this part of the work is taken away from them it, in effect, retards the movement and development of child work welfare all over the United States to a very appreciable extent. I believe that the purposes of the bill could be just as adequately met by transferring its power of enforcement to the State boards of health by means of a special division or special committee, if you choose, possibly with the same personnel that this committee has, but nevertheless working through the already organized bodies in the State departments.

We do not believe that the machinery of this bill will result in the best good to the children of the country. We believe that it will have a detrimental and harmful effect in a large number of States, and we believe that if the State's board of health can be substituted for the special and additional board, that it will be an incentive for the States boards of health to extend their child welfare work and make it much more effective than it is at the present time. We also feel very strongly on any one of these subjects relating to this that it is wrong to create additional boards. May I call attention in my own State to the fact that the governor of New York has recently sent a message to the

legislature asking that the recently established board for the control and use of narcotic drugs be abolished, and that its functions be taken over by the State board of health that is legally authorized to do that work. I feel that the policy of my own State and the policy of nearly all the States at the present time is toward more centralization instead of constantly forming new boards to do work that can be better done by boards already in existence. We believe it is self-evident and not only economic but for the greater good of the children of the United States that the machinery of this bill should be amended.

Mr. HERSEY. Will you tell me the extent of the jurisdiction of your association?

Dr. BAKER. It represents 1,200 members coming from 41 States of the Union. They are all either active child welfare workers or much interested in child welfare work. My action in speaking here to-day is by authorization of the executive committee of that organization, the American Child Hygiene Association.

Mr. HERSEY. An organization in 41 States.

Dr. BAKER. No, sir; one national organization with a membership representative of 41 States.

Mr. MCLEMORE. Would this bill affect your organization, the way it is? In what way would it affect your organization?

Dr. BAKER. It would not affect our organization in any way whatever. Our organization is simply to cover child hygiene organizations interested in the problems of child welfare.

Mr. MCLEMORE. It would not impede or interfere with your work at all then, would it?

Dr. BAKER. I think there is some misunderstanding. We are not an administrative or executive organization, Mr. Chairman. We are an organization interested in problems of child welfare all over the country. We are not ourselves, as an organization, administratively responsible individually; practically every one in the organization holds some position which would be more or less interfered with by that bill.

Mr. MCLEMORE. Admitting all that, still would your organization be hampered in any way in the world should this bill become a law?

Dr. BAKER. We feel practically the things we stand for would be so retarded in development by the passage of this bill, that the present, that is, the present administration machinery, that we are emphatic in regard to it. We thoroughly approve of the bill, simply the method of administration we object to, that it would practically retard child welfare work throughout the United States, and in the opinion of the executive committee of the American Child Hygiene Association would be exceedingly detrimental to the ultimate value of child welfare work, and the ultimate results. As we are much interested in the development of child welfare work, it would naturally retard our progress to that extent.

Mr. HERSEY. You work through the health boards of your State?

Dr. BAKER. Yes, sir. I shall be very glad to submit a short brief.

Mr. MCLEMORE. Yes.

Mr. HERSEY. I move that the brief to be submitted be put in the hearing, as a part of the statement.

Mr. MCLEMORE. Could you submit a list of the cities represented in your organization?

Dr. BAKER. Yes, sir; may I submit that later?

Mr. McLEMORE. Yes.

Mr. HERSEY. I understand the brief statement by the lady will appear in the hearing?

Mr. McLEMORE. Yes; and you will supply the list of cities, Dr. Baker?

Dr. BAKER. The brief you refer to is regarding Senate bill No. 4782, entitled "A bill to encourage instruction in the hygiene of maternity and infancy and to extend proper care for maternity and infancy; to provide for cooperation with the States in promotion of such instruction and care in rural districts, to appropriate money and regulate its expenditure; and for other purposes."

The executive committee of the American Child Hygiene Association have asked me to appear before your honorable body in regard to Senate bill No. 4782.

The American Child Hygiene Association has a membership of 1,200 persons who are directly interested in child welfare work. This membership is made up of representations from 41 States of the Union.

The executive committee of this association have directed me to present a definite statement in regard to this bill. They wish to record themselves as being heartily in favor of the purpose of the bill in question, as they believe that instruction in the hygiene of maternity and infancy and proper care for maternity and infancy are matters of supreme importance for the welfare of all of the people of the United States. They wish, therefore, to commend the purposes of this bill and to record their approval of the furtherance of its object by action of Congress. They wish, however, to express a decided protest against the machinery which is created to carry out the purposes of this bill, and on their behalf I am presenting herewith a copy of the amendments which they desire to have made in this bill. These amendments would, in effect, eliminate all references to the creation of State boards of maternity aid and infant hygiene and would provide in place thereof that the provisions of the bill be carried out by the State boards of health. They believe the machinery of the present bill to be undesirable and harmful and the substitution of State boards of health for State boards of maternity aid and infant hygiene to be desirable and proper for the following reasons:

There is in each State of the Union a health board or health department which is created to care for public health. In 11 States, divisions of child hygiene have been created under the State health authorities. The functions of these divisions of child hygiene are mainly those which promote the welfare of infants through the establishment of local divisions of child hygiene for the care of infants and young children, with a particular view to reducing infant illness and death.

The creation of a State board of maternity aid and infant gygiene, entirely distinct from the State board of health, would take away from the latter the incentive to organize child welfare work and would, in the opinion of the executive committee of the American Child Hygiene Association, mean the practical destruction of these divisions of child hygiene and the elimination of the incentive for each State to carry out proper work for the conservation of child life through the State board of health. While the bill provides for maternity aid and infant nursing, it is not probable that State boards of health will

undertake the health care of older children without the stimulus which would be provided if they already had under their supervision the health care of infants and young children. The said executive committee believe that the work of child hygiene is of such vast importance to the future of this country that this bill should not be passed, except with the amendments suggested because of its possible detrimental effect in this direction.

There is no necessity of creating this additional board, as each State has, actually or potentially, the power to carry out the work outlined for the State board of maternity aid and infant hygiene. It is contrary to public policy to establish additional boards to carry on work for which adequate machinery already exists under existing State institutions or departments. It allows duplication of effort, leaves the way open for conflict of authority, and greatly increases the overhead cost of administration. The executive committee of the American Child Hygiene Association therefore earnestly petitions your honorable body not to report this bill in its present form but to amend it so that State boards of health will be substituted in each instance for State boards of maternity aid and infant hygiene.

(The list submitted by Dr. Baker is printed below).

GEOGRAPHICAL DISTRIBUTION OF THE MEMBERSHIP OF THE AMERICAN CHILD HYGIENE ASSOCIATION (FORMERLY THE AMERICAN ASSOCIATION FOR STUDY AND PREVENTION OF INFANT MORTALITY).

The American Child Hygiene Association was organized November 13, 1909, under the name of the American Association for Study and Prevention of Infant Mortality as a result of a conference called by the American Academy of Medicine. The scope of the Association has gradually been extended to include prenatal, maternal, infant, and child care.

The name was changed to the American Child Hygiene Association January 18, 1919, as a result of recommendations made and approved at the 9th annual meeting held at Chicago December 5–7, 1918.

The association has a total membership of about 1,200. Organizations as well as individuals are eligible for membership, and the total enrollment includes 175 organizations engaged in some form of infant, maternal, or child welfare work, and about 1,025 individual members. Included in these organizations are infant or maternal welfare societies, health departments, nurses' associations, and other organizations dealing with some phase of the health of children. The individual membership, in turn, includes children's specialists, obstetricians, general practitioners, health officers, nurses, social workers, educators, and lay members who are interested in some phase of infant conservation.

Forty-one States, the District of Columbia, Hawaii, Philippine Islands, Panama, Canada, China, England, and New Zealand are represented in the membership.

The States referred to are the following: Alabama, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin. Also, Canada, Chile, Hawaii, Panama, Philippine Islands, England, and New Zealand.

STATEMENT OF MR. LEE K. FRANKEL, PRESIDENT AMERICAN PUBLIC HEALTH ASSOCIATION.

Mr. FRANKEL. Mr. Chairman and gentlemen, I am appearing here on behalf of the American Public Health Association, of which I have the honor to be president. This association is 47 years old. It was originally organized by the prominent health representatives

of the United States, and the organization eventually extended to include health men from the Dominion of Canada, the Republic of Cuba, and Mexico. In other words, it is an international organization. It has a very conspicuous and honorable history. Practically all of the work that has been done in the United States in the last 40 years in the direction of reduction of deaths from preventable diseases and particularly the extermination of diseases like yellow fever and cholera have been the work of members of the American Public Health Association, which includes in its membership men like Surgeon General Gorgas, Dr. Welch, of the Army, who is now vice president of the association, and men of that type. It has a membership of approximately 2,500, and I may say has in its membership practically every representative State health official, municipal health official, city and township health officials in the United States, including a large membership from the United States Public Health Service. It includes as well practically every representative bacteriologist, sanitarian, epidemiologist in those countries to which I have referred.

I am directed, as the result of the special meeting of the executive committee of this association, called for the purpose, to practically repeat to you what Dr. Baker has just said with respect to her organization. The association in principle favors anything that may be done for the protection of child life and, in particular, for the reduction of maternal mortality. It may be safely said that the earliest development in this line emanated from the American Public Health Association, that its proceedings and transactions show for a long period of years the great interest that this society has had in the reduction of infant mortality and maternal mortality and that it would favor any comprehensive movement that would lead to the reduction of these incidences. On the other hand, realizing that its membership is made up of public-health officers representing particularly the State organizations and municipal organizations, it believes that the present method of administration referred to in the bill under consideration is injudicious and inadvisable and will not tend to proper coordination of work. As Dr. Baker has stated, there are to-day 11 States with their efficient State health organizations, and under these subdivisions we have devoted very considerable time and thought to the development of infant hygiene and child hygiene.

Mr. McLEMORE. That is about all they have offered—thoughts. They haven't done anything practical along these lines.

Mr. FRANKEL. The eleven States to which I refer are doing rather excellent work in this direction. The other States have probably as yet no thorough organizations directed toward infant welfare and maternal welfare. On the other hand, every State in the Union to-day has a State board of health, with the exception of New Mexico, which at the present is in the throes of organization, and it appears that the new contemplated State board of health and such public-health organizations in that State will become one of the most efficient that we have. The point we raise is this, that the creation of special, separate boards for this purpose simply means duplication of effort, and duplication of effort means waste of effort; that the States have certain very distinct functions in this respect which

can not be taken away from them. It is a question there between States' rights and Federal rights which immediately comes into play.

Mr. McLEMORE. I want to ask you a question: Where have we any States' rights left? The word has lost its meaning. We have no State rights any more.

Mr. FRANKEL. Presumably under our organization, our constitutional organization of the United States, there are certain functions vested in the States, and, particularly, there are certain police powers. I take it that there is practically no one in the United States to-day who by law has more arbitrary police power than the health officer of a State, a municipality, or of a county. He may do things that are almost forbidden to anyone else. He has the right to enter your home forcibly, to remove you forcibly under the police powers that are given to him by the average municipality and by the average State in the exercise of his duties. Now, these are powers that he can not delegate and that can not be delegated by him. In other words, we have created to-day a piece of machinery whose purpose it is to administer health laws and to create health agencies. I would not for a moment attempt to discuss the value of the proposed measure. My personal record is very clear. I have for years advocated the extension of governmental aid for maternity—not as a charity, but as a pure matter of right and as a matter of wise public policy. If it were in our power to-morrow, every woman should have the right and to demand out of the hands of the authorities care during her maternal period, care during her prenatal period, and care, and, if necessary, even financial support and assistance during the postnatal period.

These statistics on this are so clear that I need not refer to them here. If you desire further data, I would be very glad to refer you to a paper that I read some years ago upon maternity insurance, in which I recounted the experience of quite a number of countries other than the United States along these lines. It is quite clear that a period of rest is needed by the average woman prior to the birth of her child and subsequent thereto, and it is only a matter of time until we in the United States accept that proposition, which we ought to encourage to the utmost. On the other hand, I feel keenly and voice the sentiments of the executive committee of this association that since we have created State boards of health that to them should be delegated the power of administration of such a law as is proposed here. It would seem to me a very small thing to amend the bill as it now reads to include practically everything that is desired by the introducer thereof and bring in all the men and women representing other departments of the State into this work, particularly to develop the educational features of this bill along with the purely health administration, and yet place the responsibility for the main administration of it where this administration distinctly and legitimately belongs, namely, in the hands of the constituted State officials, the State boards of health. I voice in this respect, as I say, the opinions of the men connected with this organization, which includes in its membership practically every secretary of the State boards of health in the United States, and practically every representative of local, municipal, and county health department in the United States.

Mr. McLEMORE. Are not the functions of the State boards of heal being gradually taken over by the National Government?

Mr. FRANKEL. I have not seen that in all the work that has thus far been attempted under the auspices of the United States Public Health Service along purely Federal lines. The effort there has been made by the service to appoint local representatives whose work has been altogether in cooperation and through the State organizations, particularly the State board of health. The Smith-Lever bill and the Lever bill now before Congress contemplates an enlargement of rural sanitation. While it may not be specifically provided for in that bill, it is intended to develop there in connection with this bill that rural sanitation and hygiene, the idea of care of infants and of mothers. That bill proposes practical cooperation and subsidy of State boards of health along lines similar to those proposed in the bill under consideration here. I would like to add just one word, Mr. Chairman, with respect to the attitude of the American Public Health Association in this matter. There is no animus back of this attitude on our part, but I am interested primarily in the development of efficiency in the health administration of the United States. At the present moment there are in addition to State health organizations, Federal health organizations, and municipal organizations; as Dr. Vincent, of the Rockefeller Foundation, put it a few weeks ago, 57 varieties of health associations in this country; every imaginable type of organization, and there can be no doubt, and it is admittedly so, that many of these organizations are duplicating each other's work—are stumbling over each other—and there is waste and inefficiency as a result. Among the things that we are planning to do at this very moment is the call of a conference in the immediate future of representatives of these organizations to see whether we can not bring about better coordination and better cooperation, and possibly in some instances the actual absorption and consolidation of organizations.

We are planning not merely for to-day, but for the future. We are trying to build up in this country what we would think is an efficient health standard. Whether this will possibly establish itself into a department of health of the Federal Government with a health minister or not, no one is at present able to say. This has been in view, as you are aware, for a number of years, and probably nothing is so much needed here at the present moment as such a department of health. But the American Public Health Association is standing at the present moment for needed coordination and cooperation for the prevention of waste and improvement in efficiency. For that reason, it believes that the creation of new agencies, unless they are specifically indicated and unless no other agencies are in existence that can not do equally as good work, is not a thing which they want to encourage or that they want to countenance.

Miss RANKIN. You also represent an insurance company; do you not?

Mr. FRANKEL. Yes; I am vice president of the Metropolitan Life Insurance Co.

Miss RANKIN. That company has used nurses for advertising their insurance; have they not?

Mr. FRANKEL. No; they use nurses to look after their policies.

Miss RANKIN. In what way?

Mr. FRANKEL. It gives a visiting-nurse service to its policy holders in case of illness with special reference to the care of mothers and of infants, and particularly to maternity care. The result of that

service has been that in five years, 1911 to 1916, where the mortality from causes due to maternity in the United States has practically stood stationary, the mortality of the company has reduced 12½ per cent.

Miss RANKIN. Is this a charity or a part of the business?

Mr. FRANKEL. The service is paid for out of the premiums of the policy holders. It is everything but a charity. It is a service to policy holders.

Miss RANKIN. Your work in that respect is not in connection with your work for the American Public Health Service?

Mr. FRANKEL. None whatever.

Miss RANKIN. How is this executive committee of the National Public Health Association formed?

Mr. FRANKEL. It is elected by the organization. This executive committee was elected at the meeting held in Chicago in December last.

Miss RANKIN. Is that a representative committee or is it a small committee from New York?

Mr. FRANKEL. The committee is a committee elected out of the board of directors by the board of directors, the board of directors being elected by the association. The board of directors has representatives in practically every State of the Union. The executive committee is elected out of that composed of officers and certain particular members elected to serve on the executive board and to act for the board of directors in the interim between meetings.

Miss RANKIN. How many men would compose a quorum at this executive committee meetings?

Mr. FRANKEL. I think five or seven.

Miss RANKIN. Are there any women on that board?

Mr. FRANKEL. To my recollection there are none on the board; no. There are women, of course, represented in the membership.

Miss RANKIN. You speak of eleven States where they have child welfare work done; could you name those States?

Mr. FRANKEL. I have here a list of nine. I was only notified of this hearing yesterday by telegraph. They are Connecticut, Florida, Illinois, Kansas, Massachusetts, New Jersey, New York, Ohio, and North Carolina. You take the State of North Carolina, for example. I do not know of a State that is doing a better piece of work at the present moment than North Carolina's health department along the lines of rural hygiene. They are quite advanced and have a very efficient State health officer, Dr. Rankin. They have gone so far as to organize dental clinics for the population of the State. and altogether their child hygiene is a distinct contribution, particularly along educational lines among women and babies, in the United States. It would seem a pity to me to go into that State and create a new agency that would take the work from them.

Mr. ROBINSON. Right along that line is a letter which you can make a part of your remarks.

Mr. FRANKEL. This letter is addressed to Mr. Robinson. I will read it:

NORTH CAROLINA STATE BOARD OF HEALTH,
OFFICE OF THE SECRETARY,
Raleigh, N. C., January 24, 1919.

Hon. L. D. ROBINSON,
United States Congress,
Washington, D. C.

MY DEAR MR. ROBINSON: I desire to direct your official attention to House bill 12634 which makes a Federal appropriation conditioned upon supplemental appropriations from States for infant hygiene in rural communities. The bill provides, as I understand it (not having seen a copy of it) that this Federal general appropriation shall be expended through some new agency to be created in the State government. Infant hygiene work is strictly public health work and it seems to me that the public health work of the United States Government should be carried on under the United States Public Health Service and not through the Department of Labor.

I have not attempted to argue that side of it at all because I do not think it has any bearing on this particular bill.

In other words that this entire measure should come under the Public Health Service and not under the Federal Children's Bureau.

Moreover, I am opposed strongly to the idea of creating a new division of the State government to look after certain health interests, reproducing within the State the mistake of the Federal Government in dividing its health work between a number of agencies or bureaus. I would appreciate very deeply your giving your attention to this bill, and using your influence partciularly against the provision of the bill that creates a new agency within the States for public health work.

Thanking you for any consideration you give this matter, I am, with the highest esteem,

Very sincerely, yours,

W. S. RANKIN, *Secretary.*

Miss RANKIN. Let me ask this question. How could it interfere with any work done in North Carolina?

Mr. FRANKEL. It would mean practically one thing or the other, if I may give my own personal views. If the Federal Government is to go into the subsidy and the State is to cooperate in getting a subsidy, it means the creation of a new agency who are going to look after infant hygiene and maternal hygiene. That work is to-day being done by the States.

Miss RANKIN. Just in New York State?

Mr. FRANKEL. As a practical case of what I mean, in North Carolina.

Miss RANKIN. They have done work for maternal aid?

Mr. FRANKEL. Yes.

Miss RANKIN. In what way?

Mr. FRANKEL. They have not, of course, gone to the extent this bill contemplates, of actually furnishing hospital care, for example, and medical care for pregnant women or for the care of the baby during or immediately after confinement, but they have taken up the whole educational side of infant welfare and child welfare work by the distribution of pamphlets and leaflets by sending nurses and physicians into the homes; by having the whole State organize public health nursing service with a supervisor traveling through the State attempting to organize in every community public health nursing work through cooperation of the communities with the State board of health, and they have taken the State from one end to the other. It has been largely rural work, for the reason that there are comparatively few cities of any size in the State of North Carolina.

Now, their work has simply been a phase of their general health work, and after all you can not detach or separate the care of the mother and the baby from the general health work of the community.

It ought not to be separated. The health work of the community ought to be considered as one great big problem, a study which primarily should come under the consideration of the State board of health. If that is well organized, I can not see any reason why the things contemplated in this bill should not be efficiently carried out.

Miss RANKIN. May I ask, then, if North Carolina is doing such excellent work, then it would have no need of availing itself of the opportunities given under this bill and could simply give that much money to some State where the health board is not doing anything?

Mr. FRANKEL. North Carolina is not a rich State; it is a poor State. It has very limited resources at its disposal. It is due to the fact that they have a very efficient State board of health with a very efficient secretary. I mention this because I happen to know the conditions in North Carolina very well. They could use this fund and very materially extend the work along the lines you propose. They would probably be enabled to authorize every woman in the State to have proper maternity care if they had hospital facilities and to give subsequent postnatal care to the baby, if they had larger funds, and could probably induce their State immediately—I speak, of course, purely from my own viewpoint—to meet the requirements of a bill of this kind, and the work in North Carolina would be immediately doubled, enlarged, and improved upon. In a maternity board, such as is contemplated in this bill, covering all the State, with representatives of the State board of health and three or four other people representing other interests in the State, who are to be the administrators, you at once take away from the State board of health its opportunity to do that work, and the work done by the State board of health inevitably disappears and vanishes. In this case it means your taking away from the State board of health and placing in the hands of an independent body work which would legitimately, logically, and legally be performed by the State board.

Miss RANKIN. Then you would take from 37 States where they have done nothing and prevent their getting anything rather than interfere with 11?

Mr. FRANKEL. I know of nothing that would encourage other States. They would go ahead and do the things planned themselves.

Miss RANKIN. You are not in favor of this bill?

Mr. FRANKEL. I beg pardon. I am not in favor of a particular provision of this bill.

Miss RANKIN. The States that have a State board of health have made no efforts. There is no reason to believe they are going to make particular effort for the mother and children.

Mr. MCLEMORE. They will do it to get this money.

Mr. ALMON. Explain what the effect of this bill, amended as you suggest, would have on these 37 States.

Mr. FRANKEL. The effect of this bill would be this thing would be published and advertised. Almost immediately, I believe, the progressive States—I speak from the standpoint of health work—would immediately avail themselves of this appropriation. That means that their work would be vastly improved and the thing that is proposed by this bill will be done. The example that will be set by these States to other States will be bound to bear fruit almost immediately. The very organization I represent is an educational organ-

ization. Its main purpose is to develop efficient health work. One of the things that we are doing at the present moment is the attempt to organize State public health organizations and associations; that is, in each State we have attempted and have organized within the last few years seven or eight of them. Others are in process of organization throughout the country. In other words, the States that have lagged behind are the ones we are trying to jack up along lines through the legitimate organization in the States, the State boards of health. Every effort of this larger organization, this national organization, would be used through its representatives and others to encourage the lagging State to come along and avail itself of the appropriation made under this bill and to induce its own legislature to make an appropriation.

Mr. ROBINSON. Is there any good reason why this work should not be done through the State boards of health or through the health departments of the Government?

Mr. FRANKEL. I know of none, sir. I have stated before that in the United States to-day that is the legal method and procedure for the administration of health rules and regulations of the States, that every State has a State board of health with the exception of one, that in most instances the State boards of health are very efficient bodies. If they have not gone into this phase of work particularly it is, perhaps, due to the fact that there are so many other things to be done by State boards of health and they have never had the funds. Here you come along and give them the opportunity to advance and develop infant hygiene work along the lines of this bill and place in their hands the money to do it and give the impetus and incentive for the State board of health to do this particular work.

Mr. ROBINSON. I remember that Dr. Rankin says he is in favor of this bill, but thinks it might be detrimental to the health boards.

Mr. FRANKEL. That is the attitude I am trying to represent here as vice president of the American Public Health Association. We have no objection to this bill. As a matter of fact, the association, as I said earlier, has been the very advance guard of attempts to procure legislation protecting infant life and maternity. No one for a moment could give anything but the best indorsement to any legislation that is going to safeguard infant life and motherhood. We believe, however, that purely as an administrative proposition it is inadvisable to establish a new agency partly lay in character, and when I say law, I do not mean lay as opposed to medical, but lay as opposed to professional health organizations, such as the board of health. There is no reason why a smaller body can not be created under the State board of health, leaving the administrative control in the hands of the State board of health.

I would ask the committee to make inquiries and find what has been done in the State of Kansas. Probably you can obtain the information through the Children's Bureau here in town or from Dr. Crunbine or Dr. De Vilbis, of the State board of health out there. If a new board is created of the type proposed here, the work already done in Kansas is to be continued and will not be distinctly interfered with.

Mr. MCLEMORE. Do you speak of insurance you were connected with? Would the enactment of this bill into law interfere there?

Mr. FRANKEL. In no way, except we are geneerally interested in this question of childhood, and as I have explained what is generally understood everywhere the situation we have all through the United States in maternity work, we have reduced the mortality among mothers from causes due to maternity 12½ per cent in five years. In that same period the mortality in the United States remains stationary, or practically, if anything, increased. The argument that this would be as our statistics would bring out is in favor of legislation directed toward proper care of women during the period of maternity.

Mr. MCLEMORE. I just wanted to bring out that one point because there seemed to be some misunderstanding.

Mr. FRANKEL. Nothing except our general interest in health work.

STATEMENT OF DR. ANNA E. RUDE, DIRECTOR, DIVISION OF HYGIENE, CHILDREN'S BUREAU, DEPARTMENT OF LABOR.

Dr. RUDE. While it is perfectly true that we have at the present time 11 State boards of health with divisions of child hygiene, you have to remember that six of them have only just been formed and are still in process of organization. Out of the five States having well-established divisions there are really only three which have been very active.

This proposed bill has a broader scope than a purely health bill. That is one of the reasons for not putting it under the boards of health, but it provides most carefully for representation from boards of health. This bill provides for a representative from the State board of health, who shall be a physician. This provision obviates the situation and States having others than physicians on State boards. For instance, a near-by State has, as president of its board of health, a printer, with a broker, a veterinarian, and four physicians as the other members. There is nothing in this bill which prevents the director of the division of hygiene in the States having such divisions, from being the person represented on this new maternity board. The bill does not say that the person has to be a member of the board of health, but a representative of this board and that he shall be a physician.

North Carolina happens to be one of the States to which this would not apply, because North Carolina has established during the past year a division of child hygiene and has at its head a home economics person. They have as yet done no work whatever. I have a letter, written in December, to that effect. I am sure the Children's Bureau has been quite familiar with Dr. Rankin's plans. He has a wonderful plan for health work in North Carolina, but the last time I talked with him and asked how many county nurses he had in his State, he assured me he had none. He has been able to do a limited amount of educational work.

Mr. ROBINSON. I do not know whether they are designated county nurses, but I know in my home county they have a community nurse. She lives in the town and looks after especially town cases.

Dr. RUDE. That is true, in certain selected localities. Dr. Rankin has really a wonderful plan for health work, if he only could have the finances with which to do this type of work. We are all watching North Carolina with great interest.

Mr. ROBINSON. I am glad my State is so progressive.

Dr. RUDE. Regarding State boards of health, I think the fact that we have to-day only five States which have Child Hygiene divisions actually in operation a very good demonstration of how slowly State boards of health act.

Mr. ROBINSON. Hasn't the main trouble been, Doctor, they haven't had the means to act with—the public has not been educated up to the point of providing funds for the work.

Dr. RUDE. That is perfectly true. That is what this bill provides for. It is primarily an educational extension bill. I can not see that it will do anything but assist the States that have undertaken this work by giving them Federal aid, and it is true that wherever work has Federal approval, it does carry more weight than where it has not.

Mr. ROBINSON. There is no doubt about that.

Dr. RUDE. There is something in the psychological effect of governmental approval. A State will go ahead and do work that otherwise it couldn't accomplish.

I didn't finish my first point regarding the personnel of this new board. The bill also provides for a public health nurse as a member. The majority of the public health nurses who are employed in States, are employed under boards of health, so that really the balance of power on this new board would be representative of the board of health, with a physician from the board of health and a public health nurse employed by them. I feel that the State boards of health were given very generous recognition in the formation of this new maternity board. The other member is to be a teacher from the State college or agricultural college. In many States it has been shown that appropriations are much more easily obtained where a State college is represented. I can not in any way see how this bill can be considered as retarding child welfare work. I am a little surprised to find myself a member of an association—American Child Hygiene Association—which feels that a bill such as the proposed one could possibly effect retardation of welfare work among children.

Dr. BAKER. May I use a personal privilege, if I may, in the record for the stenographer. If he will read the things I stated, that I appeared for the executive committee of the American Child Welfare Association, that is stated there; nor am I opposed in any way to the purpose of the bill. We have gone on record heartily in favor of the bill.

Dr. RUDE. Kansas is quoted as one of the States doing excellent work and was one of the original States having a child hygiene division. That division at the present time consists of a director, who is a physician, and three stenographers. They have been able to do some educational extension work but not the type of State-wide work such as this bill provides for.

Those are my points. Have you any questions?

Mr. ROBINSON. Is there any reason why this work should not be carried on through the recognized boards of health? I am inclined to favor the purpose of this bill, and think I do, but is there any good reason why this work should not be carried on through the established boards of health where they have them, and where they have not provide that it be carried on through boards of health of the several States, and let them establish a board of health before they can get the benefits of the provisions of this bill.

Dr. RUDE. As I think I stated before, this bill is intended to be a much broader bill than a purely health bill; its real purpose is for educational extension work and that is the reason for having it under a separate board. It is true that now all of our States have boards of health, but some of them are rather feebly organized. Many of them have not a full-time health officer, which is a very great handicap, and for that reason they are not as efficient as they might be otherwise.

The United States Public Health Service in a recent report states: "Two other basic problems, tuberculosis and infant welfare, are unfortunately beyond the direct reach of the one-man health officer, although it is possible and essential to stress these subjects in an educational way from every possible angle."

Mr. ZIHLMAN. It would be a Federal appropriation intended to stimulate health work?

Dr. RUDE. Yes.

Mr. MCLEMORE. Didn't you make a statement to take one from each board of health it really gives them the balance of power?

Dr. RUDE. One member of each maternity and infancy board would be a physician representing the State Board of Health, and another member would be a public-health nurse, and I have tried to make it clear here that the majority of the public-health nurses at the present time are employed by State boards of health, so that the balance of power would still rest in that board.

Mr. HERSEY. If they have the balance of power, why should not they have all the power?

Dr. RUDE. A person representing a State college or an agricultural college will be one very valuable means of cooperation. There you have the machinery through which to extend teaching. This bill is really broader than a simple health measure.

STATEMENT OF DR. DOROTHY REED MENDENHALL, PHYSICIAN, AGRICULTURAL EXTENSION WORK IN WISCONSIN UNDER THE SMITH-LEVER FUND.

Dr. MENDENHALL. I think Dr. Rude has proved that in nine-tenths of our States, at least, there is no machinery this bill would supersede. There is no well organized child welfare work done under the State boards of health, except in a few Eastern States. I also take exception to the assertion that the State boards of health have done heretofore in the majority of our States the best child welfare work—that is, work to promote right conditions for maternity and early infancy; that the medical profession, as represented by the State boards of health, is necessarily the best profession to administer this bill or to administer it alone, and that it would not be better to have a broader administration representing three professions, for such a bill.

I shall only touch on the point of the child hygiene divisions hitherto organized. With the exception of Kansas, where there has been State-wide distribution of educational material, but where there has been no work for the teaching of mothers in the care of themselves and their babies, except through correspondence, so far as I know the child hygiene divisions of Massachusetts, New York, New Jersey, and Pennsylvania have been the only contribution to child welfare

of the State boards of health. There is practically no child welfare work of any moment being done except in this eastern locality. The great West and South have developed no child hygiene work under State boards of health or are just beginning to start such divisions in five or six States. I am sure we are therefore not superseding any machinery.

Now, there have been other agencies doing splendid work in many of the Western States to promote health in rural communities. I am referring to the work of the extension divisions of our State universities, through which demonstrations, lectures, and actual welfare conferences are held throughout the rural districts, especially in Wisconsin, Utah, Oregon, and Indiana, and to a lesser extent in Michigan, Minnesota, and Kansas. This work in Wisconsin has been going on for over five years, and also agricultural extension work in health has been started in our State. I do not know whether you understand what extension work is. We go out to little towns, even in Wisconsin, 25 miles or 40 miles from the railroad, and there hold institutes or farmers' meetings for both men and women, and also women's meetings, where we take up among other things the health of the mothers, the question of prenatal care, the need of good obstetrical care, and the feeding of infants and older children. In the evening, at general meetings, talks are given on the health of the community and contagious diseases. Usually, in Wisconsin, we have health conferences at the end of the day, where we actually examine children, and give advice to mothers in regard to their own health problems and those of their child. Very often this is the only chance that the mother has to consult a physician. These families will come 10 to 40 miles to these conferences, because there is no other opportunity for them to consult a children's specialist. This work has been developed in many of our Western States, and I wish to say, for the sake of the other people in this work, that this is actual service for humanity, for the community. It necessitates hard and arduous traveling out into remote places, five or six days in the week, exposure to bad weather, and the danger of getting snowed up or caught all night in a stalled train. It is indeed hard, wearing work, and unless you have a real love of humanity you will not stay very long in extension work of any sort, for the salaries are quite small, practically the ordinary teacher's salary.

Appropriations to further this work have been easily obtained from the State legislatures. For instance, Utah, in 1917, was granted $5,000 by the State legislature for the child hygiene work of the extension division of the State university. The legislatures, I think, on the whole, in the Western States, the ones I know about, are glad to give funds for this extension work of the universities, while they have been less generous to State boards of health. I do not say the State board of health projects should not be forwarded, but in the West it is university extension projects that have been favored. In Iowa there is a Child Research Division for studying the conditions related to child welfare and the promotion of better health conditions for children, especially in rural districts. The State legislature, in 1917, appropriated $25,000 to start this at the State university—a very unusual example of State generosity. So much for extension work.

I am a physician, a member of both the associations which Dr. Baker and Mr. Frankel represent. It is unfortunately true in the medical profession, as in many other professions, that you rarely find the modern, scientific equipment necessary for a fine physician or surgeon coupled with a broad social knowledge, a disinterested love of humanity, and the common sense point of view, such as we used to have in the old-time practitioner. The medical profession is so exacting in its training that to be expert in branches of medicine and surgery so much time has to be devoted to professional training that the social point of view is apt to be lost. I think there are exceptions where one gets disinterested love of humanity plus that scientific medical knowledge, but I am sorry to say that in many ot the States where I have worked you are not apt to find it, in rural communities or in county health officers. The State boards of health in the past have been very largely interested in combating disease, and they have not been willing or anxious to take an aggressive in attacking the fundamental causes which injure the health of the community.

I believe the reason why they have not been willing to take this aggressive action and sometimes they have been asked to do it and, have refused, is because they are afraid of the small practitioner in the locality where they wish to undertake or start some health project. There are physicians, unfortunately, who consider their profession a money-making business and are not willing to see started in their community a project that may injure their pocketbooks. I have been told by health officers that they could not undertake work in certain places because the local practitioners would object and would go to the State medical association, which was backing the State board of health, and make trouble for them. I think that this has undoubtedly happened in some instances. I do not think any one profession is apt to see outside of their own particular field; a board composed of any one profession would not therefore be as broad minded or have as wide a vision as a board made up of several different professions.

I want to say a word about the nursing profession. It is a very practical profession. These women will very largely carry out the measures of this bill. The nurse will go into the homes and teach the mother how to care for herself and for her child and will start the centers and conferences for mothers and children and largely carry on this important part of the work. The nursing profession, as I am sure we all realize, is a profession peculiarly disinterested, with a great desire for general public service. Nursing is also a profession of women, and I think that it is only right that women should be represented in the administration of this bill, which has to do with the instruction of mothers in regard to their care and the care of their children. For another reason, I think it is an excellent thing because the nursing profession always cooperates with the medical profession, and naturally the physicians and nurses in the State board of health would work together in the administration of this bill. The nursing profession, the public health nurse, should be represented in this board.

For two reasons it seems to me that it is very much better to have the administration of this bill left as it is. One of them is that the first object of the bill is that of instruction. It is educational exten-

sion work to promote proper hygiene of maternity and infancy. Then, the carrying out of this bill involves nursing work, under the direction of physicians. Since the bill involves the use of three professions, the extension teacher, the nurse, and the doctor, and is a social and not a purely medical bill, these three professions—a teacher from the State university or agricultural college, a physician representing the State board of health, and a member of the nursing profession—should administer the bill. I can not see that this will not be a better plan than putting the administration of this bill in the hands of the medical profession alone. It is not a medical bill, but an educational extension bill. It is a social bill. It is not best for any one profession to have the administration of it. I am here to answer questions if there are any.

Dr. FRANKEL. May I correct the minutes as to the animadversions against the medical profession. Possibly I ought to consider myself fortunate in not belonging thereto. I am not a physician.

Dr. BAKER. I am a practical hygiene administrator myself and have a very extensive piece of child work under my jurisdiction in New York City. I am not speaking as an individual here, but as a practical administrator. I have been firmly impressed with the work that the public health work was doing, and that all functions of the municipality or of any part of the Government that relate to a detailed piece of work should be submitted to the part of the Government which is created to deal with that work. Crime necessarily belongs to the police department, fire prevention to the fire department, and education to the education department; the health is a function of the health department. There has been nothing said here that the public health is not eminently social in its nature. There is nothing said here that brings out the contradistinction that the bill is itself a public health bill. Its provisions are themselves recognized as public health work. The statement that was made that the nurses in this bill would be the public health nurses is not borne out by the bill itself. The bill simply says a nurse. The statement that the medical representative would be a member of the board of health is not borne out by the bill. It simply says a physician who shall be a representative of the board of health, and that means the Governor might appoint the lowliest medical inspector without administrative authority or anything else except political preference. There is no reason to believe, nor as far as I have been able to hear, have any arguments been advanced which would show wherein this work would be better carried out by that separate board than the already created health boards.

When one speaks of the delinquencies of the medical profession and the fact about a love of humanity, who are you going to use except the same ones. You will have to use through a separate board the same doctors, and nurses or health department employees. They are merely citizens of the States and with all their faults or virtues they would have to enter into any other board created. I do not see how you can possibly separete infant and child welfare work from the legal and authorized functions of any department. If you should in New York State take that part of our work away from us we would feel that we were negligent in allowing anyone to take it away from us. It is a truism that infant mortality is the sanitary index of any vicinity. The basis of welfare work and the

basis and index of all sanitation is welfare work. No board of health would delegate its powers unless the people made it do so. I believe, as an administrator of public health affairs, I can see no feature of this bill but what I am heartily in favor of the bill and its purposes, that can not be just as well performed by and through the State Board of Health and their separate boards. It is no argument to say that State boards of health have not done much. It is simply a theory that some imdependent board is going to do it better. The incentive to endeavor through States boards of health would be just as great an incentive as to some newly created board. If the State will not authorize its own board to undertake it, they will not be interested to organize any separate and independent board to begin. It is the beginning of a fine piece of propaganda work on the part of the Federal authorities to stimulate child welfare work by boards of health in the United States. It is an opportunity that should not be lost, and on the other hand, you are definitely antagonizing your health authorities by taking away from them some of their functions to no purpose. There is nothing to show that your independent board appointed will in any way be more effective than your State board of health, also appointed by the governor.

Mr. McLEMORE. Is there any positive proof that the State board of health would be any better?

Dr. BAKER. Is there any proof that your board will be any better?

Mr. McLEMORE. Is there any evidence judging from the past that your State board of health would do this work any better than proposed in this bill?

Dr. BAKER. I think that is purely a hypothetical question nobody could answer. You can not say how a board which is not in existence would do it better than a board now.

Mr. McLEMORE. You said this State board would do it better.

Dr. BAKER. I believe there is no reason to believe they will not do it as well. It is their function in life. They are appointed by the Governor. Why should a new board appointed by the Governor do it any better? Either of them will rise simply to the level of administration in that State. They will not be the same in all States; simply the tendency of the people in each State. There is nothing to show nor has any argument been advanced to show that this new board which is to be created would itself, either by virtue of its constituent elements or any inherent power it may possess, in any way be rendered more liable to do the work better.

Mr. McLEMORE. Only that this board has never been tried while the State health boards have.

Dr. BAKER. If there is a credit to anyone, it is a credit to the State boards of health.

Mr. ROBINSON. The State boards of health have not had the means to do the work.

Dr. BAKER. It is my honest conviction that this would be the biggest incentive for child welfare work through the United States, working through the State boards of health, and not only this, but infant and maternal welfare. It could be extended on a broad scale to the public schools throughout the entire child life up to the period of adolescence, without taking away from the work for the older child.

Mr. ROBINSON. Have you any good reason why you should have two sets of officers doing the same work?

Dr. BAKER. Absolutely; you are doubling your overhead, your administrative expenses. You can not take away from the health board its legal power to do this work. Therefore you are running the possibility of duplication of overhead and conflict of authority, and you are simply setting up another piece of machinery to do a piece of work for which provision is already made in every State. I can see no reason for it. I am extremely anxious to see this bill go through. I have spent my entire working life of 17 years in public health work and for 10 years have headed the bureau of child hygiene in New York State, employing over 700 people, most of whom are doctors and nurses. I have had this particular work under all the administrations. I am merely saying to you as a practical administrator that you are doing a wasteful thing which has a tendency to wipe out the orderly progress of the public health movement in which I am deeply interested, and so far as I can find out you are not gaining anything. I have come down here to hear it and I have not heard it. I do not know what the purpose is of creating a new board. Wherever the words "State board of maternity and nursing," occurs, it should simply say "State board of health."

Mr. ROBINSON. County boards?

Mr. MCLEMORE. I would judge from what you state that the main incentive to this State board of health would be the money they would get out of it.

Dr. BAKER. If you have understood that, of course, I think you have understood something which I could by no possibility have said. The States will not create separate boards unless you promise them money; no State board could do this work unless it gets public appropriations. It depends upon that for its livelihood. If the United States, the Federal Government, will give each State $10,000 a year, that would be an additional incentive. It is an important thing in any line of work. Any subsidy of that sort would be an incentive, I think, to do that kind of work.

STATEMENT OF MRS. MAX WEST, CHILDREN'S BUREAU, DEPARTMENT OF LABOR.

Mrs. WEST. May I ask a question? The assumption that Dr. Baker makes is that any State board of health is given any administrative power in this bill, that the assumption would be that the members of the State board of health are altogether qualified to carry on such work. That is not a fair assumption. I do not know whether Dr. Baker thought it was. We have State boards of health of all degrees of intelligence, and in so many cases of even full-time health officers, and in the majority of cases, without doubt, no member of the State board of health has had exeprience in infant welfare or maternal welfare work of any sort, and in many cases is hardly conversant with it. To point out that giving the State board of health this power, therefore, makes it a suitable board is assumption that possibly may not be borne out in fact. As Dr. Baker, Mr. Frankel, and all the rest of us, most of whom are members of one or the other of these associations, have said, the thing is we are

all in favor of the purposes of the bill; the membership of Dr. Baker's association, and Mr. Frankel's association, feel personally like them, and they are coming out in favor of the purpose of the bill. There can be no doubt about that. As a whole, we are all interested in having this bill carried out in the best way. It appears to us of the Children's Bureau that by the creation of a board having a doctor and public-health nurse the purpose of the bill could be carried out better. Now, if the State board of heatlh were going to be composed of people that included those three persons in their personnel—but are they? You see one great purpose of our bill is to enlist the educational forces—paragraph 9 of the bill asks that the State College of Agriculture and State University be appealed to to give instruction with, say, two or three courses of instruction in welfare work carried out through education extension. I simply ask if you put it into the State boards of health, can we then assume that the educational feature of our bill will be equally well carried out as if you had a measure which designates a board to work through education institutions.

Mr. FRANKEL. I want to suggest an amendment there.

Dr. BAKER. I want to submit a question. The governor is appointing officer for both. You can not expect to rise higher than the governor's personal predilection of his duty as governor.

Mrs. WEST. Our board of health is already appointed.

Dr. BAKER. They are appointed by each governor. They are appointive offices. In this bill the Children's Bureau has exactly the same right to outline its program through the State board of health as it would through its special committee. It has just as much control and you can have no more feeling or doubt, it seems to me, over one group of persons than over another group of persons because you do not know what your appointments will be. They may be anything the governor chooses to make them, and from my exrience as an employee in a State department, I can assure you that I believe thoroughly they will be simply political appointments in nine-tenths of the cases.

Mrs. WEST. Not if that bill goes through.

Dr. BAKER. You will not get your exalted doctors as representatives of the board of health, but some little medical inspector.

Mrs. WEST. You will get it either way.

Dr. BAKER. You will not get public health nurses, but any nurse who has enough political pull and any teacher who has the political pull.

Mrs. WEST. It provides State university or college.

Dr. BAKER. Plus her ability to get the job. There is nothing to show in either case. There is nothing that I can see that the State board of health, the same as your special board, can not do to cooperate with your agricultural college or in any way prevents or alters the possibility of extension work in child welfare.

Mrs. WEST. Will you State board take cognizance of that? Would they give these courses?

Dr. BAKER. What control will you have over your special board that you will not have with the State board of health?

Miss RANKIN. They will be representative. That is a big point as it places responsibility and specializes. This gives a special board whose sole duty it will be to carry out one line of work. That work

can not be switched off by epidemics or anything else. It places responsibility and gives them a special work to do. The fact is you can not depend upon these boards any more than you can upon the integrity of the governor, particularly in that they come in direct connection with the board. They would insist upon having a better representation and the universities will no doubt appoint the person that they ask the governor to appoint. The nursing profession will have its candidate. It makes a special board and places responsibility absolutely in giving that board the power to cooperate with every institution in the State and making it possible for every institution to feel that it is represented in that work.

Dr. BAKER. I feel that is an argument that can be advanced on any part of the government whatever. You can follow that out without limitation; you can take almost anything else away from boards of health under the same argument. It becomes basically a fundamental proposition. Are we going to, under our form of government, concentrate and centralize under one board of efficient membership the purposes for which that board was created or are we continually going to divide our efforts and place them under special offices and special boards? I think the tendency at the present time in State and Federal Governments is to have things together and eliminate useless boards. In New York State, with which I am most familiar, the present governor feels strongly in that regard. That is the impression everywhere. As far as I am concerned, I do not think there is much value in discussion of details. It is the fundamental thing that interests me. The question is whether or not the health work is to be done by the health departments. I think it could be and it should be from the point of view of the health administrator.

Mr. FRANKEL. I think there is equally the danger of overspecialization, and it is a question of overspecialization that has created 57 varieties of health organizations. In Kansas they have the Kansas society interested in heart disease, baby welfare work, baby-welfare organizations, and there are actually 57 societies in the United States at present engaged in health work. Each has its own overhead, its own officers, and I think there is an overlapping and duplication. Health work, the question of child care and maternal care, is not an entity by itself, but tied up with every phase of sickness. It is immediately connected with the problem of venereal disease and tuberculosis and questions of contagious diseases. You can not consider childhood or infancy or maternity by itself. It is the entire health of the community, and the moment you separate it from the others you do harm to the general cause. I simply want to indicate that every State in the United States has to-day a State health law as part of its organic law and part of its State constitution, and practically every one of these States under that constitution provides for a State board of health which has, as I stated, a very distinct province that can not be taken away. You are attempting to take away from the State board of health what it is now delegated to do by the Constitution.

I am not here with a brief for the State boards of health. There are any number of them that have done remarkable and efficient work. I only need to go into the question of our statistics for the last 40 years and show a review in reduction of death rates from transmissible infectious and contagious diseases. The very question

of child mortality in the United States in the last 20 years and the reduction from diphtheria, pneumonia, and other things, as compared with 20 years ago, indicates what the value of the health departments of our States have been, a very remarkable piece of work. If they haven't handled this problem yet, it is because they have not reached it. Here is the opportunity to reach it and give them the encouragement, as Dr. Baker says, and you will find every State will avail themselves of it. I see no reason why this bill should not be amended. Instead of having section 3 delegate this to a separate State board, that this be transferred and funds given to the State, provided the State board of health organizes a division of child hygiene. The money is to be paid to the State under those conditions. Under that division of child hygiene there shall be appointed the special representatives recommended here, nurse, physician, and others.

Mr. HERSEY. When you have amended that bill in accordance with your thought, what have you but simply a bill making an appropriation of so much money to each one of the State boards of health?

Mr. FRANKEL. That is what you have now under this appropriation to a special board. Of course I presume a bill of this kind ought to be so tied up with regulations that this money will not be disbursed by the Federal Government and continued unless the States produce results, irrespective of the type of administration. Surely the Government is not going to continue indefinitely money appropriations of this kind, and I think there is a provision of that kind in this bill.

(The following letters were offered for the record:)

NEW YORK, *January 14, 1919.*

DR. RUDE,
Federal Children's Bureau, Washington.

Deeply regret my inability to appear in person owing to unexpected complications here, and to speak in favor of your bill. Please present to the committee in my behalf my ardent support of the purposes of mine in the bill. Never has the need in rural districts been greater than to-day for improved oversight of expectant mothers and young children. The first and best method of accomplishing this is by a great extension of the nursing service. My hope is that this may soon be accomplished. Warm greetings.

Dr. RALPH W. LOBENSTINE.

NEW YORK, *January 14, 1919.*

DR. ANNA RUDE,
Federal Children's Bureau, Washington, D. C.

Twenty-five years' experience as head of the New York visiting nurse service is my authority for asserting the value not only the saving of life but the enormous importance of education of mothers through public health nurses. Our record show definite results and are on exhibition. The consistent decline in mortality from diseases incident to childbirth among policyholders of the Metropolitan Life Insurance Co. who have had the care of the public health nurses is in marked contrast to the increase in death rates from these diseases in registration areas of the United States. Federal aid to State to encourage the employment of trained nurses and doctors to instruct and care for women in childbirth would bring America up to the standard of other civilized countries in this respect.

LILLIAN D. WALD,
265 Henry Street, New York.

Mr. MCLEMORE. If that is all, we will stand adjourned.

(Thereupon, at 11.55 o'clock a. m., the committee adjourned to meet again at the call of the chairman.)